Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle Last, Year 20/0 Physician/ hanes 81 Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Geurge Hea conseek diAn HISHWAY 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 4-20-22 If Under 1 Year If Under 24 Hrs. 6. Sex. 1 **X** M 2 □ F 7. Age (In yrs. last birthday) Social Security Number Days **Funeral** Hours Min. 88 Yrs 24-2462 **Director** Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 20a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County filed within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 No Ur 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12506 20744 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 A Yes 2 If Yes, Give Black, White, etc. 2 No 1944 1 Never Married 2 X Married þ 1 ☐ Yes 2 🕅 No Specify Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours aft, ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Foreman 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ္ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) informant's Name/Relationship (Type, Print) MI 20744 ton Ancast 30. 1000 City or Town, State 20c. Location 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) d 22. Name and Address of Facility Funeral Service 21. Signatura 20607 1589 wagen 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arres Approximate Interval Between Onset and Death Immediate Cause (Final Leroschesti enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23h Was decedent pregnant Ectopic pregnancy Day Year Month in the past 12 months? Other (specify) Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 L g ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 2 No မှ 1 🗌 Yes 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: injury work? 5 Pending * Natural 1 Yes 2 No Investigation Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 [28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N #bl. ft watgla M 120 701 living Sta MO BB12 32. Registrar's Signature Month, Day, Year) State Registrar

DHMH .7 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month September 2010 8:45 Ruby Lambert Etta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tranquillity at Fredericktowne Frederick Frederick 8. Date of Birth (Month, Day, Yea May 27, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours 1 🗆 M 2 🕱 F **Director** 1914 220-09-8026 96 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland notified at Director 28a-f 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ŏ er than "natural", or items 23a on the Medical Examiner must be Completed by Funeral 6441 Jefferson Pike 21703 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk Manufacturing permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important, If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Winton Earl Mades Lena Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald A. Wyand / Son 701 Wyngate Drive Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 09-23-2010 | Keedysville, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA allo 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complications that conshock, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No Day Pregnant at time of death 9 I Inknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 🗌 Yes ျု 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After of the funeral by the funeral completed filled in by the funeral Natural 5 Pendina 2 🗆 No 1 Tes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) N 30. Name and address of person leted cause of death (Item 23a) (Type, Print) MD State SEP 21 Registrar

State Registrar

31. Date filed (Month, Day, Year)

Kennesh in Green

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

com

6701 N. Chiles St Sc- H 4104

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

90

SEPTEMBER

MORA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

Medical

ISRAEL ALTER mh 31. Date filed (Month, Day, Year) - -

10215 FERNWOOD ROAD #101 22. Registrar's Signature

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

20817

BETHESDA MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September Day 16, 2010 4:00 p м Physician/ Miller Gertie Jerleene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burtonsville Montgomery 2807 Duvall Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth g Birthplace (State or Foreign) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oct 21, Year)1923 Min. Months Days 1 □ M 2 🖺 F 406-26-4627 Director Usual Residence of Decedent or 28a-f show notified at show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State irector 1 ☐ Yes 2 No MD Montgomery Burtonsville ö 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö ral", or items 23a or Examiner must be Funeral with IISA 20866 2807 Duvall Road hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★★No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ White Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working 72 should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Gertie Mae Petty Floyd McKinley Fesmire permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 Duvall Road, Burtonsville, MD 20866 19a. Informant's Name/Relationship (Type, Print) Jamie Hairfield/Daughter Date 22, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State septo. 1 X Burial 2 Cremation 3X Removal from State Mt. Kenton Paducah, Kentucky 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name of States of Ferritains Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 505 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, Examiner Due to or as a consequence of): if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last certificate be executed and -trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 T No ed by the a Unknown 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident, Chronic Obstructive 1 Yes 2 No 3 Probably 4 L Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pulmonary Disease autopsy b Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate is Funeral Director; After this certificate beted filled in by the funeral director, page 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA |은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check To the I 3 □ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 17, 2010

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mio.

DOUS5593

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 31006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year :05 P M MCLECLAND 00 2010 Medical 4c. County of Death
Montgomery acility Name (if not institution, give street and number)
Brook Grove Nursing & Rehab 4b. City, Town, or Location of Death **Examiner** Olney 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year) 6/11/1918 ORTahoma 242-10-8242 92 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho almortant: If item 27 is marked outher than "natural", or items 25a or 28a-f sho and in hirty or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Mt.Airy 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 by Funeral 4315 Millwood Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. 1941 1 Never Married 2 Married X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 1946 If Yes, Give 3 → Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Andrews (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Airforce Base Electrician 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland McLelland Allie Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy M. Garnett/Daughter 4315 Millwood Road Mt.Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☑ Remove from State IredeII Mem.Gard. 9/17/2010 Statesville, N.C. 4 ☐ Donation ゟ ☐ Other (Specify) 21. Signature of Juneral Service Lie PHINTO PADDESS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner MOL Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) signed by the attending physician I be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by FIB, CORONARY Division of Vital Records, the Hospital or Attending Physician: The law requires ARTERY Completed 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? NIGHT CHOLESTEROU 24a. Was an page 2 s has autopsy performed' within 24 hours after death.

The Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Lawursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 L No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) en, Mi

State

10301

31. Date filed (Month, Day, Year)

SEP 20

201, SIL

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun,

37. Registrar's Signature

CHEORUIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 17. Physician/ 2010 8:57 aM Marie Marzullo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 503 Stirling Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🗆 M 2 🕱 F Director Yrs 1955 218-68-3511 55 D.C. July 11, Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho Director 1 Yes 2 Kno Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 503 Stirling Road USA 20901 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 K Married 1 ☐ Yes 2 🔀 No If Yes, Give <u>ک</u> Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Cake Decorator Culinary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward J. Lenart Ann Elizabeth Hanrahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Robert A. Marzullo/Husband 503 Stirling Road, Silver Spring, MD 20901 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory 1 Burial 2 Cremation 3 Removal from State Sept 0120 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Francis ddgs of collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one obuse on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hour Arrhythmia Medical Due to (or as a consequence of): Examiner 24 hours Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Atherosclerotic Cardiovascular Disease more than 10 that the death certificate be executed Due to (or as a consequence of): years attending physician a Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🕱 No Year Pregnant at time of death signed by the a g Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Depression, Morbid Obesity, Chronic Pain Neuropathy Records. 1 Yes 25 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? 2 🗆 No certificate Yes 2 x No 1 Yes After this certifica funeral director, p To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director, A

completed filled in by the f Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b signature and title of certif 29d. Date signed (Month, Day, Year) September 17, 2010 D08107 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and John Shileo, MD 18540 Office Park Drive, Montgomery Village, MD 20886 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 Calvin Franklin Mellinger 2010 1:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 858 Old Crellin Road 0akland Garrett Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth 1 XM 2 □ F Days Hours Min. 03/28/1933 Director 77 Yrs. 217-28-9722 Usual Residence of Decedent "natural", or items 23a or 28a-f shov adical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 858 Old Crellin Road 21550 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify: Navy-20 yrs+ White Specify. Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Layed Carpet Laboror Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Franklin Mellinger, Sr. Vauda Beaula Glotfelty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Stemple/Daughter 858 Old Crellin Road, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 09/27/2010 | Morgantown, WV WVU Memorial Vault Signature of Funeral Service Ligenses 22. Name and Address of Facility WVU Human Gift Registry PO Box 9131, Morgantown, WV 26506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Dans Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year signed by the a d be detached f Yes 2 No g 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 **X**No 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 1 No မ 1 TYes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medica within 24 hou

To the Fune

completed fil 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009 only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Porter

Re istrar's Senature

4th Street

29c. License number

oakland

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death r 1<u>5 2010</u> Physician/ Ang Wei Septmeber 11:10 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) Nov. 16, 1940 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Director China 69 Nov. 215-49-3417 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Exteniner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 12630 Veirs Mill Road, Apt 511 China 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: Asian If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Yu Hong Mei Yao Ping Cao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Jin Nong Huang/ Wife 12630 Veirs Mill Road, Apt 511, Rockville, MD 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Crematory 1 🗆 Burial 2 ី Cremation 3 🛣 Removal from State September 4 Donation 5 Other (Specify) 19, 2010 Alexandria, VA DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee TRACY A. STUVEK M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exeruted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician an that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death 1 Yes 2 No ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page performed 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067355 September 15, 2010

State Registrar 31. Date filed (Month, Day, Year)

SEP 1 7 2010

Daniel Kenneth Sherk, 1500 Forest Glen Road, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 14, Physician/ 2010 18:22 mest Samuel Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** ALLEGANY CUMBERLAND WMHS - REGIONAL MEDICAL CENTER 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date on L... (Month, Day Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1 🛛 M 2 🗆 F June Director 215-34-9207 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral eones Creck Hooc permit. Page 1 and 2 should be filed within 72 hours after death begartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Wee Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) lealth Departmen 9 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ൧ Worth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3906 UpperGenrees Clevilland SW Frostburg, Mary Knot 21539 lòtricia 20c. Location City or Town, State 20b. Place of Disposition (Name of Date 20a Method of Disposition Department of Important: If it any injury or o cemetery, crematory or other place) September 1 KBurial 2 Cremation 3 Removal from State 18 Moscosmile Morylone 1 Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 2010 22, Name and Address of Facility Exchange - Makenzie Funeral Home, P.A. Signature of Funeral Service Licenses 8 ECRY MOUN Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AKHEROSCIENOMIZ Physician CARDIDUASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner × 125 ABFIRS MELL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 2 🗌 No ed by the a detached f g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 17 PEALTENSION CHRONIC KEDNEY DISPASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 🗌 Yes certificate I 2 Yes within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, to 26. Place of Death (Check only one) To Be 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D42054 15 2016 TEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 SETON DRIVE, CUMBERLAND, MD 21502 DONALSON, GREGG M.D.,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 20

2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 20 Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Examiner 9. Birthplace (Spate Country) VSH-VICCIO 200100 eNursimand 8. Date of Birth (Month, Day, Year) If Unde . Sex 1 ☐ M 2 🔼 F 7. Age (In yrs. last birthday) **Funeral** Months Hours 216-05-5292 Usual Residence of Decedent Director eakater 21 1913 or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be notified at Director 1 X Yes 2 I No Maying ONACONIA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a Funeral the Me Me al Examiner must Street or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Merical Exar 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Miver Soulinchurg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Prin Front Street 000000000Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Socienter 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) unberland Gernator Cumberland Maryland 2010 22. Name and Address of Facility & East Man Street Long Coning 81555 21. Signature of Funeral Service Licensee Exhibitin McKenzie Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stare Immediate Cause (Final alzheimer's dispos end Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to lor as a consequence of sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? Month Day Veal Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's dispose 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of cetebrovascular accidem 24a. Was an autopsy death? 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) å examiner? 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: To 28c. Injury at 27. Mander of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 973 enant, 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) umbetlar 31. Date filed (Month, Day, Year) SEP 2 0 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 12:22 a^M Lambert Hamilton Miller, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2439 Fairmount Rd., Lot 39 Hampstead Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 GM 2 GF Months Days Hours Min (Month, Day, Year) 233-58-3045 Director May 19. 1938 LISA Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Carroll Hampstead MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ge 1 and 2 should be filed within 72 hours after death with the tof Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be a Funeral 2439 Fairmount Rd., Lot 39 21074 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1956-Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 1960 Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sweetheart Cup 12 <u>Dept. manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Lambert Hamilton Miller, Sr. Daisy C. Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sudie V. Miller, wife 2439 Fairmount Rd., Lot 39, Hampstead, Md. 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Department of Important: If any injury or injury or 15/2010 Manchester, Md. 4 ☐ Donation 5 ☐ Other (Specify) Kirkridge Presbyterian 22. Name and Address of Facility Eline Funeral Home Signature Funeral Service Licenses M00741 934 S. ., Hampstead, Md. 21074 Main St 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Date signed (Month, Day, Year) 29b. Signature License MJL

STIVA

DHMH 17 Rev 7/2009

Registrar

FLAVIO

31. Date filed (Month, Day, Year)

Westminster MD

South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Ma	ryland /	•				and M	lental Hy	9	201	Ω	310	13
	1. Decedent's Name (First, Middle, Last)					Certificate of Death				Reg. No. U			U	0,0	1 0			
	Physicia		Esther W. Mazel								Month Day Yea		Year 010	3. Time of	OA M			
	Medic Examin			a. Facility Name (if not institution, give street and number)					4b. City, Town, or Location of Death			4c. County of De			7.5	OA		
	Hebrew Home of Greater Washington					Rockv	ille			Montg		ntgome	ery					
	Funeral		5. Social Security Nur 101-03-8255	mber	6. Sex 1 ☐ M 2 🙀 F	7. Age ((In yrs. last b		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)		9. Birthp Count	lace (State or Try) New Yo	Foreign
	Director		Usual Residence of D	ecedent	- A			Yrs.					11/1/19	12			- New 10	
	shov dat	tor		10b. County			10c. City, To	wn or Loc	ation				-			10	0d. Inside Cit	y Limits
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an)	should and N is ma		19a. Informant's Nan				1	9b. Mailing	Address	(Street a	nd Numbe	er or Rurai	Route Numbe	er, City or 1	Town, Sta	te, Zip C	ode)	
≥ ຄົ	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The stand Mental Hygiene. The stand stand stand "Hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		William D. C		wepnew						Dell	ay be	ach, FL	33446				
סר			20a. Method of Dispo	Cremation	3 Removal from	n State	20b. Place ceme King D	of Disposetery, crem	atory or ot	e of her place)		ate /2010		cation - C Chur	-		
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		4 Donation :				King D	_			i_		72010	- 14113	Chui	CII,	n	
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	th cer ttendi	ian/	23b. Was decedent p	anths?	23c. If yes, ou	Birth 2	Fetal dea	ath 3 🗌	Ectopic p	regnancy	,			2	23d. Date		-	. 1
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120	After er dea ector by the	Certificate;	3 Suicide	6 Could n	ot be 28e. Place	e of Injury	- At home,	farm, stree					28f. Location (S		Number	or Rural	Route Numbe	er,
2	ital or urs aft ral Dir lled in				Dulid	ing, etc. ((ъресну)						City or Tow	vn, State)				
	to the Hospital or Attending Physician: Inthin 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2	Medical Ex	Physician: To the aminer: On the ba	sis of exal	mination and	d/or investig	nation, in m	v opinior	n. death oc	curred at	the time date a	and place :	and due to	o the cau	se(s) and man	ner stated.
	o the vithin o the		only one 3 29b. Signature and tit	Gurtifying	Nurse Prectioner	75 this be	ist of my kno	Windge, de	ieth occurr	License	time, date	and place	r, and due to th	e cause(s) 29d. Date	and main	or as sta	ted.	
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		Ì	30. Name and addres	s of person w	no completed cau	se of dear	ith (Item 23a	i) (Type, Pr	int) 21 M		- A		n ()	1111		110	ER 10, 2085	
			31. Date filed (Month,	SIT ()- 1/Ai	EL,	MID	01-	21 /4	DN	1/405	200	V KO	CK VI	ur	M1)	20/J	2
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		1	Stare State Registrar AMEND#24a/lopenMD,7	te of Maryland / Dep /28/2010 , g908dh /28/10 , B/W , Mcco Ce	artment of H h rtificate of D	ealth and Mental	Hygiene Reg. No.	10 31014		
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last)	r& Marks		Month Se	P Q 2	Year 3. Time of Death		
)	Examin	er	4a. Facility Name (Mot institution, give street an John Hopkins Hosp		4b. City, Town, or Baltin		4c. County	of Death		
	Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 [7. Age (In yrs. last birthday) 5 9 Yrs.	If Under 1 Year Months Days	Hours Min. 8, Date of Month	of Birth h, <i>D</i> ay, Year) 27, 1951	9. Birthplace (State or Foreign Country) Washington, DC		
	//aryland 8a-f show tified at	: F	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or Lo Baltimo				10d. Inside City Limits 1 🏹 Yes 2 □ No		
	vith the P 23a or 2 st be no	ral Di	10e, Street and Number 6333 Arbor Way		10f. Zip Code 21 28	7	10g. Citizen of V USA	What Country?		
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 X No s, Give or Dates.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Specify Yes on Mexican, Puerto Rican, etc.) Specify:		e - American Indian, sk, White, etc. Caucasian		
	vithin 72 hours iene. r than "natur the Medical E	Completed	15. Decedent's Education (Specify only highest grade comp	oleted) 16a. Dece (Give	edent's Usual Occupa e kind of work done di DO NOT use retired) abled	ation uring most of working	16b. Kind of Bi	usiness Industry		
	d be filed w Mental Hyg arked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Bernard S. Berry	, Sr.		18. Mother's Name (First, Manargaret C	ddle, Maiden Surname)Wens	9)		
	d 2 should alth and h 27 is ma er traume		19a. Informant's Name/Relationship (Type, Print Jacqueline Berry/S	Sister 19b. Mai	ling Address (Street a	nd Number or Rural Route N View Centr	umber, City or Town, Seville,	State, Zip Code) VA 20121		
	permit. Page 1 an Department of He Important: If iten any injury or otho		20a. Method of Disposition 1	1 1272	ematory or other place Memoria	1 2010	B' Fairf	- City or Town, State		
Balt	permit. Departr Import any inji		21. Signature of Funeral Service Licenses		Iome, 990		Rd., Fai	irfax,VA 22032		
	nysician/ Medical Examiner	niner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, library leading to immediate cause. Enter Underlying							
092	cate be executed physician and s the burial-transi	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	ne to (or as a consequence of):	14/6					
. Box 68760	Attending Physician: The law requires that the death certificate be ex or death. ector. After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial	Physician/Medic	in the past 12 months?	es, outcome of pregnancy Live Birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	☐ Ectopic pregnanc	у		23d. Date of delivery Month Day Year		
ls, P.O.	uires that t n signed by		Part II. Other significant conditions contribution	ng to death but not resulting in the	e underlying cause giv		bacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Cunknown			
Division of Vital Records,	The law ate has page 2	Completed by	25. Was case referred to medical		26 PI		autopsy performed? Yes 2 No	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒No		
Vita	ysicial is certi	To Be	examiner? 1 Yes 2 Hospita	1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 DOA Othe	er: 4 Nursing Home 5	Residence 6 Oth			
on of	nding Plath. r: After the	Certificate:	2 Accident Investigation	n. Date of injury (Month, Day, Year) 28b. Time injury	work work	y at ? Yes 2 \(\sum \) No	Describe how injury occurred			
Division	al or Atte		4 - Homicide determined	. Place of Injury - At home, farm, s building, etc. (Specify)		City	or Town, State)	reet and Number or Rural Route Number, , State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	(Chook 2 Modical Evaminer: On	o the best of my knowledge, deat the basis of examination and/or inv tioner: To the best of my knowledge	estigation, in my opinio	on, death occurred at the time.	date and place, and di e to the cause(s) and n	nanner as stated.		
	2 Total		29b. Signature and title of certifier When a -	3 pmp.		27718	5 C P	ed (Month, Day, Year) 4, 2010		
_			30. Name and address of person who completed Willie W. R. Ving	11 MA 5755	Ceda-L	-ane Coly	mbia, Mi	aryland 21044		
	Sta Registi		31. Date filed (Month, Day, Year) SFP 1 6 2010	32 Registrar's Signature	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g908, 10/08/2010 dhb

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Saptember 23 2010 Physician/ Lulitu Mengesha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham Doctor's Community Hospital 9. Birthplace (State or Foreign 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs, last birthday) **Funeral** NOV 3, Days 1 🗆 M 2 💢 F Hours Ethiopia 72 Director 578-13-4270 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 X No Maryland | Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number Ethiopia Funeral 20743 6404 Adak St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give þ 1 ☐ Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nursing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Akale Aredo Mengesha Tilahun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6404 Adak St. Capitol Heights, MD Solomon Zewdu/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State Fairfax Mem. Park 09/27/2010 Fairfax, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Fairfax Memorial Funeral Home 9902 Braddock Rd., Fairfax, VA M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cirrhosis Liver Physician/ disease or condition resulting in death) Medical Examiner Herato Collular Sequentially list conditions. Examiner it any, leading to immediate cause. Enter Underlying Herbors requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit ACATION APPROVED Cause (Disease or linjury that initiated events resulting in death) Last kid ne Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day 1 Yes 2 s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 \(\) 1 ☐ Yes 2 ☐ No 2 X No 1 TYes 26. Place of Death (Check only one) Division of Vital Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ျ 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: (Month, Day, Year) injury 1 🔼 Natural 5 Pending 1 🗌 Yes 2 🗎 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0059981 9/23 muchmil And ella, my 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MUKE mil
31. Date filed (Month, Day, Year)

SFP

27 2010

ABDELLA, M.D

12200 Annapolis Road #229;Glendale, MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day sugene McDonoug 8 2010 4a. Facility Name (If not institution, give treet and number) 4b. City, Town, or Location of Death 4c. County of Death Nashin withzore (esstow Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Hours Min. Nov. 6 1933 216-30-3452 76 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9722 Chaplewood Lane IISA 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1951-54 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronics n Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Muriel McDonough Virginia Locke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9722 Chaplewood Lane, Hagerstown, Md. 21740 Genevieve McDonough - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 9/22/2010 Hagerstown, Maryland Rose_Hill Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Minnich Funeral Home +415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophareal Cancer With Due to (or a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

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items 2

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Department of Health ar Important: If item 27 Is any Injury or other trau

Director

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death

Pages 1 and 2 should be filed within 72 hours after

3altimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be ٩

bunial-tran attending p detached rate has been signed by page 2 should be detach certificate this Certification:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 1+1

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an autopsy

1□ Yes

2**X** No

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

5 Pending investigation

25. Was case referred to medical examiner?

1 Yes

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

2[**X**No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Dav. Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

(Item 23a) (Type, Print)

Marshpi Itujensdown MD 31. Date filed (Month

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Physician/ 3:24AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical pous nne Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F none Director ansland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director evensville 1 🗌 Yes 2 🗷 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral Mariners nited states 21666 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Completed by 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: Jhite If Yes, Give salvadoran 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Najarro Tejada Marvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevensville Rom Way 10 tather Marines 20a. Method of Disposition 20c. Location - City or Town, State
Tapalhuaca, LaPaz, 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 🔀 Removal from State Municipal Cemetery 4 Donation 5 Other (Specify) Salvador ΕÌ PHNI IPADOS RIANALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 9241 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the Interval Between Onset and Death Immediate Cause (Final Physician/ a Intractable disease or condition Medical resulting in death) **Examiner** Bilateral grade Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events coulding in death). Last Examiner the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Xtreme prematu
Due to (or as a consequence of): Extreme been signed by the attending physician and resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 2 2 N 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number H42733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 isch Do 31. Date filed (Month, Day, Year) State Registrar

Please Type of Print in Black Indelible Ink 1 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) North **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 04/05/1918 1 □ M 2**X**F Months Days Hours MD **Funeral** Yrs 92 220-32-9552 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State Show 1 Yes 2X No Examiner must be notified at EASTON Director TALBOT MD 28a-f 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō UNITED STATES 9557 BLACK DOG ALLEY 21601 or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Specify: 1 ☐ Yes 2X No Specify Baltimore, Maryland 21215-0036 ģ 3 XWidowed 4 Divorced "natural", 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Hygiene. HEALTH CARE REGISTERED NURSE 11 h and Mental Hygien 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NINA MAY SNIVELY ARVEY DWIGHT MILLER ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6030 NEWTON RD., PRESTON, MD 21655 of Health in item 27 i NORMAN JERRY NORTH / SON other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition # of 1 XBurial 2 Cremation 3 Removal from State 09/16/2010 CORDOVA, MD FAIRVIEW CEMETERY permit. Page Department of Important: If any injury or once. 5 Other (Specify) 4 Donation 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 ral Service 21. Sig and e of 5 t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death) nemorrhade **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner SAMPLE APPROVED BY MEDICA the attending physician and ched for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy Year Live birth 2 Tetal death Month Day 4 Pregnant at time of death in the past 12 months? 5 Other (specify) 2 No Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 No 1 Tes Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, Be examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 □ DOA 1 Inpatient 2 ER/Outpatient မ 28a. Date of Injury (Month, Day Year) After this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a Hospital 29a. Certifier Medical (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-2010 DOW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Ducku losh 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 15 2010 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** September 28 2010 1225 Michael John Onifer, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 13, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F Yrs 198-22-3355 81 1929 Pennsylvania **Director** Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene. at Hygiene. other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modical Examiner must be nothered at 1 X Yes 2 ☐ No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Pennsylvania Avenue 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes ≥ 200 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Legal/Banking permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth, any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael J. Onifer, Sr. Susan Malanev 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Onifer, III/Son 147 E. Main Street, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date September 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 30, 2010 West Chester. PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** myocardia minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a donsequence of): the attending physician and ned for use as the burial-tran resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by i page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1∐Yes 2.27No 1 ☐ Yes 2 ☐ No After this certification, property of 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after decral Directors After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) (20005526 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.K. hristine Horal 31. Date filed (Month 32. Red rar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 15, September 3:24 p Physician/ Clara Roberta Ohler 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Carroll Hospital Center Westminster Date u. (Month, Da, 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Day, Mary Land 1 M 2 X F 78 214-30-1750 Dec Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State aţ Director Taneytown notified Carroll 1 Yes 2 No Maryland 10g. Citizen of What Country? the 10f. Zip Code 10e. Street and Number ò Examiner must be 21787 Funeral with 1 23a 45 Middle Street USA items filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No Specify white permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exar Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shoe Factory Seamstress 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marjorie Worthington ပ Norman Raver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37 1/2 Middle Street, Taneytown, MD 21787 Jeffrey Ohler, son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Pleasant Cemetery 9/18/2010 1 💢 Burial 2 🗌 Cremation 3 🗋 Removal from State Taneytown, MD 4 Donation 5 Other (Specify) Myers-Durboraw Funeral Home Signature of Funeral Service Licenses 22. Name and Address of Facility 136 E Baltimore St, Taneytown, MD 21787 intai 93a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Abdomina disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Y ROUTS Vascul Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 Yes 2 No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Manner of Death Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

Rusenterd 31. Date filed (Month, Day, Year) SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 29b. Signature and title of certifier

(Check

only one)

Greene Tree Road - # 420 1855 32. Registrar's Signature ack

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Isalimore, MD 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 10, Year 2010 Physician/ ADDIE GERTRUDE PFLEEGER 7:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT WILLIAM HILL MANOR EASTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Hours NEW YORK 1/18/1924 86 Director 112-20-0031 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State Director ms 23a or 28a-f si must be notified 1 ☐ Yes 2 🛣 No MD TALBOT **EASTON** 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 28337 OLD COUNTRY CLUB ROAD 21601 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify 3 Divorced Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 2 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GERTRUDE O'GORMAN EDWIN WICKMAN traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CANDACE A. TAUBNER, DAUGHTER 1015 WASHINGTON AVENUE, PELHAM MANOR, NY 10803 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State GATE OF HEAVEN 4 ☐ Donation 5 ☐ Other (Specify) 9/16/2010 HAWTHORNE, NEW YORK 21. Signature of Funeral Service Livinsee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P
200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between CEREBROUNSCULAR Physician/ disease or condition Medical resulting in death) FTHEROSCLEROTIC CARDIOVASCULAR DISEASK Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be the IF FEMALE: nse 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENTIA ATRIAL 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a, Was an has performe 1 ☐ Yes 2 No 1 ☐ Yes 2 🗙 No this certificate or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Hospital pleted filled Medical

State Registrar

DHMH 17 Rev 7/2009

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the

29a. Certifier

only one)

29b. Signature and title of cer

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BLOOMINDALZ AUE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registra MEND#8+19 aperINF, 9/23/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ CHARLES Μ. PETERSON eptember 14,2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM 8. Date of Bir 6-22-1915 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🕅 M 2 🗆 F Days Months Hours WASHINGTON, DC 1915 **Director** 225-05-3627 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 28a-f MD. PRINCE GEORGES GREENBELT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 event, the Medical Examiner must be 23a Funeral 4D RIDGE RD. 20770 U.S.A. items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced WWII Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. D.C. GOV'T. 12 ADMINISTRATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 DREWS permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. **JACOB** Ε. PETERSON KAREN Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Peterson F. PETERSON/DAUGHTER Karen KAREN RIDGE RD., GREENBELT, MD. 20770 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD. 9-15-2010 CHAMBERS CREMATORY 21. Signature of Funeral Service Licensee 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Assiration €hysician/ disease or condition resulting in death) preumonia Medical Due to or as a consequence of Examiner disorder swallowing Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury use as the burial-transit cerebrovascular accident death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician atrial Physician/Medical fibrillation Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month 2 🗌 No detached 9 Unknown 9 Unknown o. p To the Hospital or Attending Prystuan, which 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an polymyalgia rheumatica autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 54

31022

3. Time of Death

3:45 A M

10d. Inside City Limits

Onset and Death

months

months

months

1 🏋 Yes 2 🗆 No

Registrar DHMH 17 Rev 7/2009

State

erson who completed cause of death (Item 23a) (Type, Print)

Schi

31. Date filed (Month, Day, Year)

D22780

7500 Greenway Ctr Dr. Greenbelt, MD 20770

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amended Item 23a Part I Line b per Phy. 09/22/2010 Carroll Co., will state of Maryland Department of Health and Mental Hygiene

For State Amend Item 7 per fh,g908,10/14/2010dhb

Reg. No? | | | for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 14. 2010 7:20 P Eleanor May Ptak Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove House Westminster 9. Birthplace (State or Foreign Country) NY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 83 82 Director 059-22-4242 Sept. 29,1927 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show 1 XYes 2 ☐ No Director r than "natural", or items 23a or 28a-f si the Medical Examinar must be notified Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 66 Timber Ridge Dr U.S.A. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Completed by 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, Ite Magnet. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lina Gauthier Joseph Parent မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Kirkham/daughter 7716 Twin Oaks Way, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation 9/20/2010 Hampstead, MD 22. Name and Address of Facility Pritts Funeral Home and Chapel 21. Signature of Funeral Servic Lice Lee 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Days Rhabdomyolysis Sequentially list conditions. Examiner Due to for es e consequence offi cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical as for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ ₩6 Ö detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to redical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2 🗖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 27. Mann of Death 1 4 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stone 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 14, 2010 ear Edward Joseph Penfield 9:43 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X**□ M 2 □ F September 14, Year 24 555-20-9458 86 **Director** Usual Residence of Decedent 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomery Silver Spring MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11748 Lovejoy Street 20902 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite Completed 3 X Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natu ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Communications Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward F. Penfield Josephine Perrotta 19a. Informant's Name/Relationship (Type, Print)

Josephine A. Demirkan/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16013 Normandy Court, Woodbridge, VA 22191 Sept. 20 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) entomioment cemetery, crematory or other place) Gate of Heaven Cemetery 2010 Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph sician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Candida Peritonitis Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): executed Cause (Disease or iinjury Bowel Perforation the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical th certificate be Duodenal Ulcer Division of Vital Records, P.O. Box 68760 P.O. Box 68760 Hospital of Attending Physician: The law requires that the death certificate D IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? as been signed by the atte 2 should be detached for Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CVA, Brain Cancer 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital of Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed?
Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🗵 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D63579 Sept. 15, 2010

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

D. Name and addess of person who completed cause of death (Item 23a) (Type, Print)
Maria Tayag, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dominick John Pennessi 4 : ناف PM Scokmbe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Hagerstown Washington County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 26, g. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** Days Min. **XX**M 2 □ F 073-16-1459 Director 88 Usual Residence of Decedent and More are the hygiene. 'is marked other than "natural", or items 23a or 28a-f show 'is marked other than "natural", or items 23a or 28a-f show are avent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Co. Direct Hagerstown 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13004 Woodburn Drive 21742 U.S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 X Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify:White 3 → Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical and injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Aviation Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosario Pennessi Anna Scillipote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Pennessi / Daughter 6012 39th Ave. Hyattsville. MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Vet. Cemetery 9-23-2010 Flinstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Immediate Cause (Final Sepsi's Onset and Death Physician/ disease or condition resulting in death) 4100K Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit resulting in death) Last Lymphaderopath Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown ned by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

Sompleted filled in by the fi Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 9/17/20/0 D 00 68995

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

1/30 opal ct.

Registrar's Signature

Haperstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 8,2010 Physician/ 3:40 P. M Jean Liberty Pennock Medical 4a. Facility Name (if not institution, give street and number) c. County of Death
Prince Georges 4b. City, Town, or Location of Death **Examiner** Mitchellville Collington Episcopal Life Care 8. Date of Birth
(Month, Day, Year)
June 8,1910 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2 🕱 F 579-22-5462 100 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director Mitchellville MD Prince Georges 1x Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important if frem 27 is marked other than "natural" ---- any injury or other traumatic events. Funeral 20721 10450 Lottsford Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married þ Specify.White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Consumption Economist 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Childs Tadd David Sands Brown Pennock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1023 Bluebird Ave., Santa Clara, CA 95051 Carol P. Elland/Niece 20a. Method of Disposition September8 20b. Place of Disposition (Name of 20c. Location - City or Town, State Geo. Wash. University Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 2010 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Ligenses 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months Dav Year 5 Other (specify) Pregnant at time of death led by the a detached f Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 Yes 2 1 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has this certificate 2 🗆 No Yes 2 1 \square Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 within 24 hours after oeau..

To the Funeral Director: After this c ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes atural 5 Pending 2 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier

State Registrar

rar SEP 2 0 2010 anna D. Jan

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Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #7 & Per INF G920 10/12/2011 JH
For Amend Item 25 per me, g908, 10/20/2010dhb
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Physician/ Rosetti - Galindo 2010 Jose 1555 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Month, Day, Year 1929 . Sex 1 Ø M 2 □ F Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 81 Months Days Hours Director 730-05-7061 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Yes 2 X No Takoma Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20912 7903 Cole Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 9 1 Never Married 2 X Married Maryland 21215-0036 1 X Yes 2 □ No Specify: White Completed 3 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Evila Galindo Agustine Rosetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7903 Cole Avenue, Takoma Park. Maryland 20912 Manuel Rosetti - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State Date 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Lincoln Crematory: 09/28/2010 | Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, Cardiopulmonary Arrest disease or condition Medical resulting in death) Examiner Intraparenchymal Brain Bleeding if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Suicide Investigation Could not be filled in by the 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tit September 23, 2010 D65069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 MD. Sirak Hagos Lemma.

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 September 9:40 A Edward Hugh Rankin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Talbot Hospice Easton 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) C 18, 1920 1 🛛 M 2 🗆 F Months Days Hours Min. New York 89 **Director** 074-12-5084 Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Talbot Easton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral United States 21601 17 Kensington Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or item edical Examiner n was beceden Ever in 6.6.

Armed Forces?

1

Yes 2 □ No
If Yes, Give
Year or Dates. 1942–46 Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 Divorced Completed White th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Material Handling Elementary/Seconday (0-12) College (1-4 or 5+) Sales Engineer <u>Equipment</u> Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be file Department of Health and Mental P Important: If Item 27 is marked of any injury or other traumatic even once. ည Edith Reilein Samuel Fergusson Rankin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Easton, Maryland 21601 17 Kensington Drive Laura Ellen Rankin/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 🔯 Cremation 3 ☐ Removal from State Journey Crematory 9/21/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si parure of Funeral Service Lice vee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 noma 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Ph sician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of sician and burlal-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) been signed by the sahould be detached Linknown g Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown extension 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1 Yes 2 No death? 1 Yes 2 No 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tes ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar

completed

29a. Certifler

29b. Signature and title of certifier

ldlen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

47232

Shields, mo

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 31029 State of Maryland / Department of Health and Mental Hygiene 20 10 1-State Amend #17, 9-24-2010, per FHDR entire of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Physician/ 2010 1:00p M Peter Fotheringham Ross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5103 Wehawken Road Bethesda Montgomery 8. Date of Birth
(Month, Day, Year)
Sept 24, 1929 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** Months Days 1 🛛 M 2 🗌 F Director **France** 577-36-4781 80 Sept Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 United States 5103 Wehawken Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married "natural", or ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 1953-55 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Cartographer Map Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Claudius Ross Catherine Fotheringham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5103 Wehawken Road Bethesda, Maryland 20816 Jacqueline P. Ross/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State injury Final Journey Crematory 9/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Domos uanto M00957 23a. Par 11 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary years) Medical resulting in death) Due to (or as a consequenc * f) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 No 1 Yes 2 9 Unknown as been signed by the 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page certificate Yes 2 **N**O 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) • Hospital or Attending Pl 24 hours after death. • Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by determined 24 hours a Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9-17-2010 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Precard G. Coleman

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 1 2010

RECURS

10-07127 Elbert Reed

				21	010	31030
0-07127 Elbert Reed		Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hyg		ible.	0 , 0	
Libert Need		1- For State Certificate of Death Registrar	Reg. No.			
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle Last)	Date of Death Month I September	Day 16 2010	/aar	3. Time of Death 1213 hrs
Medical Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	oeptember		ty of Death	0
Funeral		204 South Augusta 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth	(MM/DD/YY	YY) 9. Birth	place (State or
Director		222 - 38 - OGT 1 KM 2 F 56 Yrs. Months Days Hours Min.	Feb 1	2,195	Foreign Cour	
any	F	Usual Residence of Decedent 10a. State			1	10d. Inside City Limits
≱	ţ	10e. Street and Number 10f. Zip Code	1100	Citizen of	What Count	1 Yes 2 No
± 4 € 1	Director	204 South August the 21229	,,,,	W	A	,
ath with th items 23a	Funeral	11. Marital Status 12. Was Discedent Ever in U.S. 1 Never Married 2 Married 12. Was Discedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Version of Hispanic Origin?) (Specific Version of Hispanic	cify Yes or No- can, etc.)		nce - America hite, etc.	an Indian, Black,
after des	를 교	3 Widowed 4 Divorced If Yes, 2 No 1 Yes 2 No specify: or Dates:		Specif		rck
2 hours after "natural",	ted t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		16b. Kind of	Business/In	dustry
0036 within 7 iene. er than Medica	Completed	17 Father's Name (First Middle Last)	SOY	aldon Sumo	Hee	1
21215-0036 hould be filed within 7 nd Mental Hygiene. is marked other than afte event, the Medical	Be C	17. Father Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Y Middle, Ma	1061	elv	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withis Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur 5 1 0 0 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ral Route Numb	er, City or T	own, Stale,	Zip Code) 43008
re, M 1 and 2 F Health Fitem 2	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Locatio	on - City or T	own, State
Baltimore, permit. Pages I an Department of He Important: If ite Injury or other to		4 Donation 5 Other Specify: 21. Signature of Fune all Service Licensee 22. Name and Address of Fability (VM)	22 200	Ches	HU 10	unship, MA
Bal permi Depar Impo injur		P.O. BOX 2593, W	rilmina	itm. 1		1805
Physician		23a. Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arres	shock, or	heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (First disease or condition resulting in death) a. Neck Injuries Due to (or as a consequence of):				
	ř	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	xamine	cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death). Last				
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760, cate be physicis	/Medi	#23a,ptllperME,G908,10/14/2010,w			of delivery	
ox 68760, alth certificate be execut attending physician and or use as the burial - train	sician/Medical	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	;y	Month	ı Da	ay Year
). Bo the dear	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use co	ntribute to th	ne cause of death?
s, P.(od be	Acute And Chronic Alcohol Use				ubly 4 Unknown
cords law requests been law	Completed by		24a. Was ar autopsy perform	red?	prior to co death?	opsy findings available impletion of cause of
I Re(n: The rtificate or, page		25. Was case referred to medical 26. Place of Death (Check onl	1 Yes 2 ly one)	No	1 🗸 Yes	2 No
f Vita Physicia or this ce	To Be	1 V Yes 2 No	Home 5 R			Scene
on of ending l ath. or: Afte		1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No No	ubject fell d			
Division of Vital Records, P.O. Box 68760, na or Attending Physician: The law requires that the death certificate b ars after death. "In Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the bu	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28	8f. Location (St or Town, Sta)4 South Agu:			al Route Number, City
hou hou		29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and ducknowledge.	ue to the cause	(s) and man	ner as state	
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated. 29b. Signature and tiple of certifier 29c. License number				cause(s)
	-	296. Signature and use of centrer of the control of			per 17, 20	
)	ŀ	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201			
Sta	ate	// co Project Company	.201			
Registi	rar	DET & I LUIU Chana B. Jake				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Clifton A. Ross 12:45P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 109 Clipper Way Chestertown Kent 5. Social Security Number Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min Month, Day Year 6/24/191 Director 219-07-9111 97 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Kent Chestertown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Clipper Way 21620 United States Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Ross Bertha Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Mary E. Ross - Wife 109 Clipper Way Chestertown, MD 21620 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 9/18/2010 Ardent Cremation Hanover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Puneral Service Licensee M01411 4112 Old Columbia Pike Ellicott City, MD 21043 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Odset and Death Immediate Cause (Final Physician. disease or condition resulting in death) 0 200 Medical Due to (or as a consequence of) Examine Durer asstrointes mo Sequentially list conditions Examine trany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? hypertension 24a. Was an certificate has performed 1 Yes 2 No 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury Natural 5 Pending Accident 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0021732 of person who completed cause of death (Item 23a) (Type, Print) 3 Chestertown, MD 21620 Delboy 6602 Churchill Rd. Ste. 200 31. Date filed (MonSEPYZ)0 State egistrar's Signature Backe Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Paul Tuson Richards September 2010 4:00 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 3809 Wilberta Street Olney Mon topomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. 579-68-6338 61 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Olney 1 ☐ Yes 2 🎮 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 3809 Wilberta Street 20832 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within : ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Union Negotiator Hotel/Restaurant and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ 27 is marked or traumatic e Abraham Richards Mildred Laverne Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Richards/Wife 3809 Wilberta Street, Olney, MD 20832 Department of Health Important: If item 27 any injury or other t 20a. Method of Disposition Sept^{Date}20 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 d Cremation 3 Removal from State cemetery, crematory or other place) Metropolitan Crematory 2010 4 Donation 5 Other (Specify) Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, Md 20901 23a. Part 1. onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Cirrhosis of Liver 5 vrs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year sate has been signed by the page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinsonism Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 funeral director, nours after death.

neral Director: After the filled in by the funeral within 24 hours 0

Accident Suicide

29b. Signature and title of certifi

4 - Homicide

29a. Certifier (Check

Medical

Edward P. Taubman, 18109 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year) Registrar's Signat 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

d23459

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month. Day. Year)

Sept. 16, 2010

City or Town, State,

Tations known as USIE Row

			For State	State of Marylan		artment of H tificate of L			2010	21023		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate of L	Jeani	2. Date of Deat	eg. No. U	3. Time of Death		
	Physicia Medio		Leslie Thressa	Ross				Scotent	160 11 2510 16 46 M			
	Examin	er	4a. Facility Name (if not institution, give stre Sinou Hosert	at and number) 4b. City, Town, or Location of Death BALT MOKE C				iti	4c. County of Death			
	Funeral		5. Social Security Number 6. Sex	7. Åge (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign		
	Director		220-80-6573 1 1 1 1 1 1 1 1 1	M 2 🔀 F 47	Yrs.	Wolling	Tiours I with	10/24/	1962 MD			
	yland f shov ed at	ctor	10a, State 10b. County MD Carro		y, Town or Loc mpste					10d. Inside City Limits		
	he Mar or 28a- o notifi	Dire	10e. Street and Number	11 110	mps ce	10f. Zip Code		1	0g. Citizen of What C	1 Yes 2 No		
	n with t is 23a nust be	Funeral Director	4521 Whetstone	Court		210	74		ÜSA			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	H	Vas Decedent of H Yes, specify Cuba	n, Mexican, Puert		14. Race - Ame Black, Whit Specify: W			
15-(72 hou n "natu Aedica	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give k	ent's Usual Occup kind of work done (O NOT use retired)		rking	16b. Kind of Business	Industry		
212	within giene. rer tha t, the I		Elementary/Seconday (0-12)	College (1-4 or 5+)	ı	tgage b	anker		banking			
and	be filed antal Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) James Kane					ne (First, Middle, M Benbri	,			
ary	should be file and Mental 7 is marked of raumatic eve		19a. Informant's Name/Relationship (Type,		19b. Mailin	g Address (Street	and Number or Ru	ral Route Number,	City or Town, State, Zi	p Code)		
ď	and 2 s Health em 27 ther tra	. 7	Alan Michael Ros 20a. Method of Disposition				one Cou		pstead,			
mor	age 1 ent of I nt: If its		1 ☐ Burial 2 ★ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crem	sition (Name of natory or other plac Cremat		1	20c. Location - City or Hampste			
Baltimore,	permit. Page 1 a Department of I Important: If it any injury or of		21. Signature of Funeral Service Licensee	O M007	41 22	. Name and Addre	ss of Facility E1	ine Fun	eral Hom	e		
	TD = # 0		23a. Part 1. Enter the disease, or complica						tead, Md	Approximate		
F	hysician/	, J	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Application on the stress of the stre									
	Medical Examiner	resulting in death) a. Due to (or as a consequerice of):										
	physician and the burial-transit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):							:		
		xam										
9		edical										
3876	ertificat ding ph	/Mec	IF FEMALE:	. If yes, outcome of pregna	nov							
). Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. to the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown						23d. Date of de Month	blivery Day Year		
s, P.O.	ires that signed t d be det		Part II. Other significant conditions contri		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
Sord	aw requas been 2 shoul	Completed by	Acute Renal F	aluke				24a. Was ar autops		24b. Were autopsy findings available prior to completion of cause of		
Rec	sician: The la certificate ha rector, page							perform 1 \sum Yes 2	ned? / death?	s 2 DNo		
Vital	ysician s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	pital:	ER/Outpatien	Oth	er:		nce 6 Other (Sper	rifu)		
Division of Vital Records,	lo the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Certificate: 7	27. Manner of Death 1 M Natural 5 □ Pending 2 □ Accident Investigation 3 □ Sulcide 6 □ Could not be	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Ho				lome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
Divis	al or Att s after d l Direct d in by i		4 Homicide determined	 Place of Injury - At ho building, etc. (Specify, 	ce of Injury - At home, farm, street, factory, office ding, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funeral Director.	Medical	(Check 2 Medical Examiner:	in: To the best of my knowle On the basis of examination ractioner: To the best of my	and/or invest	igation, in my opinio	on, death occurred	at the time, date and	d place, and due to the	cause(s) and manner stated.		
			29b. Signature and title of certifier	2 1 0 0 11	20)	29c. License	number	25	9d. Date signed (Mont	h, Day, Year)		
	MIL		30. Name and address of person who comp	oleted cause of death (Item	23a) (Type, P	rint)	7-00	321	reclere +	Green Spring		
			Sessica Rean	ton po	Sina	i Hos	outal.	of Ba	limor	21215		
	Stat Registra		31. Date filed (Month, Day, Year) SFP 1 4 201	32. Registrar's Signat	ure A. A	ake						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17^{Day} Month 9 20^{Year}0 Evelyn Rivera 7:00 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Waldorf 1105 Heritage Place A Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗀 F Days Hours Months 0*2^MP8thTP*1^y1^y9^r59 044 66 7874 51 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Charles Waldorf MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20602 1105 Heritage Place A USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Never Married 2 Married þ Maryland 21215-0036 White 1 Yes 2 □ No Specify: PuertoRican If Yes, Give Year or Dates Specify. Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Health Aide Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 2 Ramon Rivera <u>Carmen Rodriquez</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manuel Rivera 3461 Waldorf,MD 20602 Orchid Pl.Unit Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Cypress Hills Cem. 09/20/2019 Brooklyn, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.G Ortiz Funeral Home 21. Signaturé of Funeral Service Licen ambell 2580 Grand Concourse Bronx, NY 10458 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Metastatic Breast Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined . 24 hours a e Funeral เ Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F 3 🗌 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) addless of person who completed cause of death (Item 23a) (Type, Print) 30. Name and #201

Registrar

31. Date filed (

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 10, Physician/ 2010 845 PM M Roberts Schanbam Dorothy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 9707 Old Georgetown Road #2306 Bethesda 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 0270171919 Bayonne, NJ **Director** 158-12-1525 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 x Yes 2 ☐ No MD Montgomery Bethesda 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 20814 United States 9707 Old Georgetown Road #2306 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
If Health and Merked other than "natural", or items other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 XNo
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: Completed 3 ♥ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harry Schanbam Sadie Meltzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Bradley Blvd, Bethesda MD 20814 Steven Victor Roberts - son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 09/17/2010 Woodbridge, NJ Beth Israel Cem. 21. Signature of Fu e Licensee Remorial Chapels Inc. 170 Rockville Pike Rockville MB 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Lung Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the ard be detached for 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 🙀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Cardiomyopathy 24a. Was an autopsy performed Yes 24 has page 2 this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d, Describe how injury occurred After injury 1X Natural 5 Pending 2 Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical

24 hours after death. Funeral Director: A completed within 2 To the F 2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Yea 29b. Signature and title of certifie 29c. License number September 14, 2010 D26607 Culled of

🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7625 Wisconsin Avenue #101, Betehsda MD 20814 Edward T. Cullun, MD

Registrar

29a, Certifier

31. Date filed (Month, Bay, Year,

10

10-07197 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Daniel Alejandro Recinos State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Daniel Alejandro Recinos **Medical Examiner** 1208 hrs September 18, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs, 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Hours Director coManryland 6/24/2010 220-87-4309 1 X M 2 F Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d, Inside City Limits Adelphi 1 Yes 2 X No MD Prince George 28a-f shor other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once, Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 USA 1910 Saratoga Drive uneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 2 X No Yes El Salvadoren White 3 Widowed If Yes, Give Year 1 X Yes 2 No specify: 4 Divorced Specify "natural", ≦ 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within 72 hours Health and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) none MD 21215-0036 none 0 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jacqueline Alas is marked Wilberto Saul Recinos æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 7 8 3 19a. Informant's Name/Relationship (Type, Print) father Baltimore, MD
permit. Pages 1 and 2 sho
Department of Health and
Important: If item 27 is Wilberto Saul Recinos/ 1910 Saratoga Drive Adelphi, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State George Washington 9/24/2010 Adelphi, Md. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Spec 21. Signature of Funeral Service PHILIPADS RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Sudden unexplained death in infancy (SUDI) Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED 27,28a-f,per ME g909 11/30/10 TT the attending physician ed for use as the burial certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed death? 1 🗸 Yes certificate ✓ Yes 2 No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 No unk within 24 hours after death. Director: d in by the f Pending Fd 10:00 am Fd 9/18/10 Accident Investigation 28f. Location (Street and Number of Rural Route Number City #TO Town, State 11306 Evans Trail #T2 Hyattsville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide found at home To the Funeral I determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001

OCME 2006

one)

29b. Signature and title of certifier

Patricia Aronica-Pollak MD.

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

Registrar's Signat

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 19, 2010

10-07309
Mary Ellen Ring

0-07309 ary Ellen Ring		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene										
ary Eller King		For State Certificate of Death	nontal rijgi	Reg. N	10.201	0 310	137					
Physicia ledical Examii	ın/	Registrar 1. Decedent's Name (First, Middle,Last) MARY ELLEN RING	2. D N S	Date of Death Month Da eptember 2	y Year 3, 2010	3. Time of De 0600 hrs						
4	ı	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca 201 Walden Drive Fruitland	eation of Death		4c. County of Wicomico)						
Funeral Director		5. Occial Security Harrison 5. Sex	If Under 24Hrs. 8. Hours Min.	Date of Birth(M		Birthplace (State Foreign Country)	or					
Aaryland 28a-f show any <u>1 at once.</u>		Usual Residence of Decedent		100.0	Citizen of Wha	10d. Inside C						
th the Maryland 23a or 28a-f sho notified at once.	E E	201 WALDEN DRIVE 21826			United	States						
after death witi al", or items 2 iner must be n	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced of Free Parks: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No sp	exican, Puerto Rica	an, etc.)	White, Specify:	WHITE	ack,					
21215-0036 Ild be filed within 72 hours after Mental Hygiene. narked other than "natural", event, the Medical Examiner	ompleted t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 NURSING	O NOT use retired)			OICAL						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once	Be Co	WALTON B. HORNER, JR.	Mother's Name (Fire CATHERIN	NE RYAN	BENTON							
	٤	19a. Informant's Name/Relationship (Type, Print) CATHERINE RYAN BENTON 19b. Mailing Address (Street and 23231 Paul Be		rcle, N	Wenona,	Md. 2182	.1					
		20a. Method of Disposition 1 Name of Cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls U.M. Ceme. 20c. Location - City or Town Wenona, Md.										
Balti permit. Departn Imports		21. Signature of Funeral Service Licensee M00295 22. Name and Address of F	set Ave.	nan Fund Prince:	ss Anne	, Md. 218						
Physician M i al	-	234 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line. Immediate Cause (Final disease a. Diphenhydramine intoxication	sh as cardiac or res	spiratory arrest,	shock, or hear	t Approximat Between O Dea	nset and					
Examiner	ĺ	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.										
	aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):										
executed an and al - transit	ical Exa	d	TT									
tox 68760, teath certificate be attending physici for use as the buri		IF FEMALE: 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of o		Year					
P.O. Bires that the disigned by the	ð	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.			oute to the cause of o						
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed			24a. Was an autopsy performe	<u>d</u> ? de	ere autopsy findings ior to completion of ceath? Yes 2						
tal Recision: The certificate	Be C	examiner?	Death (Check only			0						
of Vid Physic er this	10	1 Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at		d. Describe how	sidence 6 🗸							
Sion of Attending Phydeath.	cation	Natural Natural Pending Investigation Natural Fd 9.23.10 Fd 5:52 am Yes		ibject omedicat	ion		nber, City					
Divis spital or A sours after neral Direction tilled in the site of the site o	Certification	Accident investigation investigation and accident investigation investig										
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date a work one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deand manner stated.	eath occurred at the	e time, date and	place, and du	e to the cause(s)						
F # F S	Me	29b. Signature and title of certifier O.C.M.E			9d. Date signe September	d (Month, Day, Year, 24, 2010)					
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	D 21201									

State Registrar

Ling Li, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year) SEP 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month FRANK ALBERT SAATHOFF, JR. Sept 2010 10:44 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare 5. Social Security Number | 6. Sex Talbot The Pines Easton 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Davs 1**X** M 2□ F 86 212-40-7873 01-22-1924 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 10421 THREE BRIDGE BRANCH RD. 21601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Tes 2 X If Yes, Give Year or Dates: 1 ▼ Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISABLED DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HILKA GELDEN FRANK A. SAATHOFF, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10421 THREE BRIDGE BRANCH RD., NIECE EASTON, MD 21601 LINDA BROWN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEM. PARK 09-08-2010 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS. HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST., EASTON, MD 21601 HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10013 disease or condition resulting in death) Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last weeks IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work?

Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and burialattending physician for use as the buria the as the

Box 68760,

P.O.

Records,

Division of Vital

Physician

/Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or

Director

Funeral

9

Completed

Be ပ

injury or other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event

Frank Saathoff Baltimore, Maryland 21215-0036

signed by it icate has been si ; page 2 should b certificate director, this

Examiner Physician/Medical ð Completed Be P Certification: After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

RS5

To the within 2

State Registrar

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 □Yes 2 □No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Name and address of person who completed cause of peath (Item 23a) (Type, Print)

ROWL

5 Pending investigation

6 Could not be determined

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

610 gistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Physician/ 2310 PM John F. Sullivar 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical Center Baltimore 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 27, 1935 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 ← M 2 □ F 577-46-9413 75 Washington, DC Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Adelphi MD P.G. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 10813 Pleasant Acres Drive 20783 USA · death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Yes Give þ 1 Never Married 2 😾 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: White Year or Dates. 1958-61 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Covernment Affairs Lobbyist traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked or permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ၉ Charles Joseph Sullivan Rose Fitzmorris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia D. Sullivan/Wife 10813 Pleasant Acres Drive, Adelphi, MD 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept^{Date}24 cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Mount St. Mary's Cemetery Emmitsburg, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2(1901 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sizasz disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner lo months failure Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Firansit Exami 7 months Myocardial Infavenor and Due to (or as a consequence of) resulting in death) Last physician sthe burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No the 9 Unknown as been signed by 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 **N**No 4 Nursing Home 5 Residence 6 Other (Specify) ြု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1578798310 MD September 16,2010 ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

<u>Jennifer</u>

31. Date filed (Month, Day, Year)

M.

5. Greene St.

Baltimore, MD 21201

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:00 A.M ^{Day} 12,2010 Stafford Physician/ Josephine Janet September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Manor Care If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) ug. 24,1908 1 □ M 2 🔀 F Months Days Hours Min. Country)
Unknown 578-48-1626 Director 102 Aug. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD Montgomery Rockville 1 X Yes 2 No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6917 Old Stage Road 20852 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Public Schools Teacher Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lee Hoffman Myrtle May Alber Werner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Stafford/Son 6917 Old Stage Road, Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown University Medical Center Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Acute Myurashin Due to (or as a consequence of): INFARCTION Medical resulting in death) Examiner ENERD DEBIL Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events re to (ur es e consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been significated filled in by the funeral director, page 2 should it 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?

1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 1.5mo 9-17-2010 D-17874 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COTTAGE CITY, MD 20722 3717-38" S. M. NAYAR AVE

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marion Smart Sinderson 2010 9:55 A M September Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Rethesda If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Min 004-16-3353 1 M 2 F 10/10/1919 Maine Director 90 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director MD Bethesda 1 🖺 Yes 2 🗌 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20814 items 23a Funeral 5913 Cheshire Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3[™] Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Mary Cowie 17. Father's Name (First, Middle, Last) Thomas Smart permit. Page 1 and 2 should by Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1519 Blue Meadow Road Rockville, MD 20854 Thomas G. Sinderson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Crematory 09/19/2010 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, A complications that classed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia 4 Davs disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 ding p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year signed by the a d be detached f 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Incarcerated Femoral Hernia, Small Bowel Obstruction, 1 ☐ Yes 2 ANo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes, Hypertension autopsy Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 🔀 No ၉ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 💢 Natural 5 Pending Accident Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

P.O. To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director, After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, **Division of Vital** 10

> 30. Name and address of be James Robey edicause of death (Item 23a) (Type, Bright) Old Georgetown Rd. Bethesda, MD 20814 8600 31. Date filed (Month, Day, Year) State Registrar

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Cod Date signed (Month Day)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

50113

29d. Date signed (Month. Day. Year)

2010

Medical

29a. Certifier

(Check

only one) 29b. Signature and title d

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:00p M Helen G. Strats September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Silver Spring Montgomery 328 University Blvd. East If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 30. 1909 Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛭 F Days Hours Months Director 101 047-24-6759 Greece Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 328 University Blvd. East 20901 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked on any injury or other traumatic eve Panagiota Zuras Paul Mantzouranis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Panagiota Strats - Daughter 328 University Blvd.. East. Silver Spring. MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 09/21/2010 Silver Spring. MD 4 Dollation 5 Other Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Sen |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transi that initiated events that the death certificate be exec resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death a Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 N certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 \square Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af Investigation
6 Could not be 1 Yes 2 🗌 No Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотрыете (Check Ce tifting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 6110 1700 21234

Registrar DHMH 17 Rev 7/2009

State

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Vinu Ganti, MD, 10301 Georgia Ave., #203, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ella Bertha Sims September 15, 2010 Year 10:14 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday Funeral 8. Date of Birth Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F Months March 6, 1925 163-24-5466 85 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD 1 🗆 Yes 2 🏝 No Mon top mery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3112 Gracefield Road, Park View 209 20904 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ŏ à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 thand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Engineering Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Emery Sheranko Elizabeth Balog 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f and 2 soft Health item 27 Carol Harback/Daughter 3167 Pine Orchard Lane, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of cemetery, crematory or other placel ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 18, Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ Metabolic Acidosis Medical resulting in death) Due to (or as a consequence of) Examiner Small Bowel Obstruction 8 hrs Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of). resulting in death) Last attending physician for use as the buria Physician/Medical certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2X No g 🗌 Unknown g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown been signated should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has it performed? Yes 2 1 N 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: I nin 24 hours after death. the Funeral Director: After this certifica npleted filled in by the funeral director, p **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No ၉ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work Accident
Suicide Investigation 1 Tes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one) 29b. Signature and title of 29c. License numbe

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Parkhurst, MD 3110 Gracefield Road, Silver Spring, MD 20910

D24093

29d. Date signed (Month, Day, Year)

Sept. 16, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ Month Mackina 10/161 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lawer Gearges Oreel Road 200100 If Under 24 Hrs. 8. Date of Birth Birtholace (State or Foreign Country) **Funeral** 1 M 2 KF Months Days Hours (Month, Day, Year, Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No 10e. Street and Number -00GC001100 10f. Zip Code 10g. Citizen of What Country? Funeral sec Georges Creek Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 🗹 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David tanles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) leaise Kunt-0924 Mexico Forms Department of Healt Important; If item 2 any injury or other Mari Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State مطديطي View Cemeter 4 ☐ Donation 5 ☐ Other (Specify) Moscoumils, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Erchhorn-McKento Fu Maylar 2150 SEGST MOIN 4cmo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appr ximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical renal disease or condition resulting in death) MIONIC Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Oncerning Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnanτ a g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 🗷 Residence 6 🗆 Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury_at 28d. Describe how injury occurred 1 X Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Example 2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar homas

31. Date filed (Month, Day

20

Douglas Ave Longconing,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of M Registrar	aryland / Depa Cer	artment of H tificate of D			ene g. No. 2010	31045		
			Decedent's Name (First, Middle, Last)				2. Date of Death	ate of Death 3. Time of D			
	Physicia Medio		Inez Lucas Schwent				September	$r^{\text{Day}}14$, 201	0 12:20 p ^M		
	Examin		4a. Facility Name (if not institution, give street and number) Long View Nursing Home		4b. City, Town, or Manch	Location of Death		4c. County of Death Carroll			
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9, B	irthplace (State or Foreign		
	Director		253–28–5581 1 □ M 2 📜 F	90 Yrs.	Months Days	Hours Min.	oct 18,	1919 G	eorgia		
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits		
	Aaryla 8a-f s tiffied	Director	Maryland Carroll		W	estminste	er		1 ☐ Yes 2 X No		
	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 1801 Benedict Road		10f. Zip Code	21157	10	og. Citizen of What C	Country?		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent in Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No If	Was Decedent of His f Yes, specify Cubal I Yes 2 X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: wh	ite, etc.		
21215-0036	nin 72 hour ne. than "natu r e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or t	(Give F iife. DO	dent's Usual Occupa kind of work done d O NOT use retired) Waitress		ing	6b. Kind of Busines Restau			
d 21	ed with Hygier other i	Be C	11 17. Father's Name (First, Middle, Last)	aiden Surname)	-anc						
<u>lan</u>	l be filed v fental Hyg rked othe tic event,	뎯	Walter Allen								
Maryland	d 2 should be file alth and Mental I 127 is marked o ir traumatic eve		19a. Informant's Name/Relationship (Type, Print) Allen L. Lucas, son		City or Town, State, 2						
Baltimore,	Page 1 and nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo Souten crem Carroll C	sition (Name of natory or other place	9/16	Date 2 /2010	Oc. Location - City of Winfield			
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	oraw Funer ter, MD 2	cal Home 1157						
ı	23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.										
	Physician/		Immediate Cause (Final	1.1.					Interval Between Onset and Death		
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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ${\tt September}^{\tt Month}{\tt 11}$ Physician/ Snyder Carroll Leonard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ★ M 2 □ F Months Hours Min. (Month, Day, Year 90 219-05-1776 Director 1920 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location at Director MD Sykesville ir than "natural", or items 23a or 28a-fs the Medical Examiner must be notified Carrol1 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 7200 Third Avenue M513 21784 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 72 hours after Specify: white If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 within 7 College (1-4 or 5+) USPS assistant postmaster permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumation Be 17. Father's Name (First, Middle, Last) Katie L. Seibel William Newman Snyder 19a. Informant's Name/Relationship (Type, Print) Mr. Michael Snyder (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 9 - 14 - 104 ☐ Donation 5 ☐ Other (Specify) Olive Cemetery 21. Signature of Funeral Service Licensee Para Ktupiok. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. VCF PHA LO PATH Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) -transit requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🗌 No 1 Yes 2 9 Unknown Unknown P.O. by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an autonsy page Yes 25. Was case referred to medical after death.

Director: After this certific Be Division of Vital 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work?
1 \(\sum \) Yes 2 \(\sum \) No Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifier WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5930~ Glen Falls Rd., Reisterstown, MD 21136~20c. Location - City or Town, State Randallstown, MD 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Date signed (Month, Day, Year) Center Street Westminster HD 21157 South

3. Time of Death

11:38a

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Country) MD

2010

Carroll

Black, White, etc.

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

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H.Q

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sebtember 14, 2010 Lenore SCHWARTZ 9:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery Brighton Gardens If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Days Feb. 17, Yea 1936 Hours 480-58-0518 1 □ M 2 □ **y**F 74 Iowa Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No Maryland Montgomery Chevy Chase 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20815 United States 5555 Friendship Blvd., #621 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. white 1 Never Married 2 Married Completed by 1 Yes 2 1 Tes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates I Hygiene. other than "natura ent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Schwartz Ruth Goldman permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print)
Cynthia Caplan, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6910 Hillmead Road, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place udean Memorial Gardens 09/15/10 21. Signature of Fur eral Service Liv Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer 6 Years Immediate Cause (Final Physician/ Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) ending physician and ruse as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 Ă 9 ☐ Unknown a 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Valvular Heart Disease autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours a To the Funeral D Medical 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nuese-Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of co

State Registrar Margot G. Whee 31. Date filed (Month, Day, Year)

SEP 1 6 2010

Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Wheeler, M.D., 3800 Reservoir Road, NW, Washington,

who completed cause of death (Item 23a) (Type, Print)

MD31331

20007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month ep 24, 2010 Physician/ Sr. 12:39 pm Szwast Anthony Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany 12841 Meadow Avenue Cresaptown 9. Birthplace (State or Foreign Country) PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 M 2 D F Months Hours Feb 6. ^{Yea} 1935 190-26-4157 Director Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at death with the Maryland Director 1 Xes 2 No MD Allegany Cresaptown 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 21502 USA 12841 Meadow Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 X Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Designer Draftsman Paper Mill Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ၉ Sophie (Bunk) Szwast Peter Szwast 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Cresaptown Rose Szwast Wife 12841 Meadow Avenue Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/27/2010 MDRestlawn Memorial Gardens LaVale 21. Signature of Funeral Service Licenses 22. Nam Straffellis Fulfiella Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consecuence of Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 2 KNo 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: hin 24 hours after death. the Funeral Director: After mpleted filled in by the funeral 1- Natural 5 Pending
Investigation injury work?
1 Yes 2 No Accident
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the P within 2 only one) 29b. Signature and title of co 29c. License number Sept 24, 2010

State Registrar 32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Gupta M.D. 31. Date filed (Month, Day, Year)

0 4 2010

100332EU

625 Kent Avenue Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10 01 020	riease Type of Film in black indelible filk. Elisure All Copies Are Leg
Hermie May Saunders	State of Maryland / Department of Health and Mental Hygiene

	1- For State Ceres Registrar	rtificate of Death	Reg. No. 2 1 1	31049							
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Hermie May Saunders		Date of Death Month Day Year September 23, 2010	3. Time of Death 1630 hrs							
medical Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death									
	Washington County Hospital	Hagerstown	Washington								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	Time 2 1062 Foreig	hplace (State or n Mary Land untry)							
any	Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Location		10d. Inside City Limits							
<u>≱</u>	lar a also al	erstown		1 X Yes 2 No							
th the Maryland 23a or 28a-f sho notified at once.	124 Clarkson Ave.	21742	10g. Citizen of What Coun								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 XNever Married 2 Married 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.								
urs afte	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify: 16a. Decedent's Usual Dccupation (Give kind of v	work done 16b. Kind of Business/Ir								
5-0036 ed within 72 hour lygiene. the Medical Exal Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti Homemaker	Personal F								
5-0036 led within 7 Hygiene, 1 other than the Medica	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surname)								
2121 Mental I Marked c event,	Richard Calvin Saunders 19a. Informant's Name/Relationship (Type, Print)	Pear 1 At 19b. Mailing Address (Street and Number or F	rmstrong Saunders	Ti Outu							
AD 2 shou h and h and h and T is mmatic	Cecil R. Baltimore-fiance	124 Clarkson Ave. Hag		Zip Code)							
re, real fresh fresh fresh fresh fresh fresh fresh fresh fresh		Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or	Town, State							
Baltimore, permit. Pages I an Department of He Important: If ite Injury or other or	4 Donation 5 Other Specify:		8-2010 Hagerstown	·							
Bald permit Depart Impor	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery F 1331 Eastern BLvd. North Hagerstow										
Physician	23a. Part I. Enter the disease, or complications that caused the death.	r respiratory arrest, shock, or heart	MD 21742 Approximate Interval Between Onset and								
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Intracranial hemorrhage, Non-traumatic or condition resulting in death) Due to (or as a consequence of):										
	Sequentially list conditions, b										
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	,									
760, ricate be executed physician and the burial - transit //Medical Exal	events resulting in death) Last Due to (or as a consequence of d.):									
60, ate be execu hysician and reburial - trr	X UNPENDED ☐ AMENDED 23a,27,per 1	ME g909 11/1/10 TT									
8760, ifficate by ing physic as the but	23b. Was decedent pregnant in the	nancy 2 Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month D	ay Year							
n of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed. After this certificate has been signed by the artending physician and tuneral director, page 2 should be detached for use as the burial - transion: To Be Completed by Physician/Medical E.	past 12 months? 4 Pregnant at time of de			.,							
O. B at the d by the tached tached / Phy	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	he cause of death?							
S, P.O. uires that the signed by d be detacted ed by Fed b			1 Yes 2 No 3 Proba	ably 4 🗹 Unknown							
Records, The law requires ficate has been signage 2 should be Completed			autopsy prior to co	opsy findings available ompletion of cause of							
			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	s 2 No							
irector	25. Was case referred to medical examiner? 1	26.Place of Death (Check of ER/Outpatient 3 DOA Other Nursing									
of V ig Phys fher thii neral di	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred								
ion trendin leath. tor: A the fu	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No									
Division of Vital Records, spital or Attending Physician: The law requir nours after death. neral Director: After this certificate has been stifled in by the funeral director, page 2 should the Certification: To Be Completed	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rur or Town, State)										
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.										
F \$ F 5	29b. Signature and title of certifier	29c, License number	29d. Date signed (Moni								
	Carot Hallan	O.C.M.E.	September 24, 20)10							
in		^{23a)} 111 Penn Street, Baltimore, MD 2120	1								
State Registrar	32. Registrar's Signatu (Month Day Year) 22. Registrar's Signatu (Month Day Year) 22. Registrar's Signatu (Month Day Year) 23. Registrar's Signatu (Month Day Year) 24. Registrar's Signatu (Month Day Year) 24. Registrar's Signatu (Month Day Year) 25. Registrar's Signatu (Month Day Year) 25. Registrar's Signatu (Month Day Year) 26. Registrar's Signatu (Month Day Ye	re Ki									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day 04/08/2010 23:18 PM <u> Annie G. Swinson</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Clinton Prince George's <u>Southern Marvland Hospital</u> Social Security Number Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 M 2 K Hours 242-42-3526 78 02/25/1932 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Prince George's Clinton 1 XYes 2 No MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5334 West Boniwood Turn 20735 AZU death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 KWidowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Clerk Express Mail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Caroline Estelle Ellis James Edward Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Swinson / daughter 5334 West Boniwood Turn, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland National Cem 09/17/2010 Laurel, MD 21. Signa ure f Funeral S , vir e 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, MYOC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES, TYPE 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 1110 1 Tes within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 Yes 2 No Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

SEP 2 0 2010

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sep 27, 2010 Year Searles 10:00 Dr. David Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany County Nursing and Rehab Allegany Cumberland 5. Social Security Number 84 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) PA Hours ^{(Mgnth}, ^{Day}, 4^{ear)} 1948 218-48-9348 Director 62 Usual Residence of Decedent f show permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marianal. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany LaVale 1 □XYes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 730 National Highway 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Psychologist** Psychology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John D. Searles Ada E. (Davies) Searles 19a. Informant's Name/Relationship (Type, Print)

Dinah Searles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 National Highway LaVale MD 21502 Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Scarpelli Funeral Home. P.A. 1 Burial 2 Tremation 3 Removal from State 9/29/201b MD Cresaptown 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address III Full Fral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 🗌 Probably 4 🗌 Unknown 1 🗌 Yes 2 🗹 No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death _heck only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🥎 3. Time of Deat 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day 4. Physician/ Tupler 2810 Louis 4:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date of Day, (Month, Day, Days 1 X M 2 □ F Months Hours Country) Illinois 577-24-4998 Tan. **Director** 87 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Maruland Montgomery Kensington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 3620 Littledale Road 20895 United States 12. Was Decedent Ever in U.S. Armed Forces?
1

Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1944-1945 1 ☐ Yes 2 😿 No Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working The Washington Modern permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Artistic Director Dance Societu Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tupler other traumatic Beniamin Jacob Sadie. Rappaport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul N. Singer / Nephew 2415 Veluet Ridge Drive, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Judean Mem. Gardens 9/16/2010 4 Donation 5 Other (Specify) Olney. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. F ar the d'ea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, / r heart fa ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Fina disease or indition resulting in death) Cerebrovascular Stroke Priyolcian/ Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 D Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an After this certificate has funeral director, page 2 autopsy perform Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) atel Jayanti 10052586 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

1500 Forest Glen Road, Silver Spring.

Jayanti Lalbhai Patel, M.D.

. Registrar's Signa

31. Date filed (Month, Day, Year)

SEP 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene FoAMEND#20b per FH Certificate of Death Registrar 9/17/2010 AACO HEALIH DEPT ONH Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 14, Physician/ 2010 1:15 AM Hugh Alexander Turnbull, Jr. Medical la. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Crofton Convalescent Center 7. Age (In yrs. last birthday) If Under 1 Year g. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number Funeral 1 X M 2 □ F Months Days Hours Min. New Jersey Yrs 93 1916 **Director** 144-01-8916 Nov Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Anne Arundel Crofton Marvland 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1708 Wickham Way 21114 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, an "natural", or iter Medical Examiner Black. White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. If Yes, Give Year or Dates. WWII Specify: White 3X Widowed 4 Divorced Completed 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working United States life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Federal Government Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh Alexander Turnbull, Sr. Helen Kokajko t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1708 Wickham Way Crofton, MD 21114 Karen Shangraw/ Daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott race of Disposition (Name of Cametery, crematory or other place) ATITOTAL ATIONAL CEMETERY 1 X Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Arlington, VA 21. Signature of Faheral Service Lic 22. Name and Address of Facility Robert E. Evans Funeral Home Road Bowie. MD 20715 16000 Annapolis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due V The law requires that the death certificate be executed Cause (Disease or linjury as the burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death asn 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Pregnant at time of death 5 Other (specify) ed by the a Unknown 9 Unknown been signed the should be detected to the sh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s has 1 Yes 2 No certificate Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Rakesh Arora, M.D. 14300

14300 Gallant Fox Lane Bowie, MD 20715 Suite 222

SEP 1 6 2010 32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

law requires that the death certificate be execute

attending physician and for use as the burial-trar

s been signed by the should be detached

funeral

within 24 hours after death

To the Funeral Director: A

Medical

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Health a

other

Baltimore, Maryland 21215-0036

la or 28a-f show the notified of

ral", or items 23a Examinar must I

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the unc	derlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 □Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othor	ath (Check only one)	6 ☐ Other (Specify)
27 Manner of Death Natural 5 □ Pending investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not be determined	28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)		
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death miner; On the basis of examination and/or investant manner stated.	occurred at the time, date and placestigation, in my opinion, death occ	e, and due to the cause(urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifie	X	29c. License number	29d. D	ate signed (Month, Day, Year)
Dhall to	8"	D3988-	1 9	-13-2010
30. Name and address of person who	completed cause of death (Item 23a) (Type, P	Drive Suite 3	301 East	on, MD 21601
31. Date filed (Month, Day, Year)	32. Registrar's Signature	back		

State Registrar

DHMH 17 Rev 1/2001

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Physician 19 7:15a ^M Mildred Josephine Turnbull 2010 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cecil 1850 North East Rd. North East 8. Date of Birth (Month, Day, June 1, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 👿 F 1926 84 MD Director 197-12-1504 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Expropriment be notified at 1 ☐ Yes 2 ☑ No Director MD Ceci1 North East 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21901 USA Completed by Funeral 1850 North East Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Court System 12 Judge's Secretary Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental James C. Marano Felicia Gibbs other traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Steven Walklett/ son 1850 North East Rd. North East, MD 21901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State R.T. Foard Funeral Home, P.A. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD Name and Address of Facility T. Foard Funeral Home 9 E. Main St. ELkton, 22. Na R . T 259 21. Signatur Home, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** ance We /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician or Attending Physician: The law requires that the death certificate be Physician/Medical attending ISe 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ו 24 hours a Puneral ב Hospital 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29d. Date signed (Month) Day, Year) 29b. Signature and titl 30 Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Exam				Location of Death	4c. County of Death Allegany			
		Moran Manor Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last b	Western	Iport If Under 24 Hrs.	8 Date of Birth		Birthplace (State or Foreign	
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d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	Ш	19a. Informant's Name/Relationship (Type. Print)	9b. Mailing Address (Street	and Number or Rura	al Route Number,	City or Town, Sta	ate, Zip Code)	
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DIVISION I or Attending after death. I Director: Afte	Cartification.	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 9 ☐ Suicide 9 ☐ See Place of Injury - At home, building, etc. (Specify) Front of home			City or Town, Frostbu	State) 24	or Rumal Boute Number, 6 Talcott Ave.	
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10		30. Name and address of person who completed cause of death (Item 23)	a) (Type, Print)	MD 2153	2			
_	State	Jesus Tan, M.D. 4 Broadway 31. Date filed (Month, Day, Year). 32. Registrar's Signature	La del	4133 س	۷			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 76, 2010 **Physician** 1125 Terry Shawn Toncic /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Y No V . 19. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1√ M 2 F 232-11-0518 Director 48 Ohio Usual Residence of Decedent death with the Maryland 10a. State 10b. County Show 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Cecil Marvland Conowingo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 101 Windmill Road 21918 U.S.A. or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ified within 72 hours after I Hygiene. other than "naturel", or ite 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 1 (
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Vulcanhart Elementary/Secondary (0-12) College (1-4or 5+) Dundalk, Maryland Four Years Project Manager 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If Item 27 is marked oth y injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Ivan T. Toncic, Sr. Beverly Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Windmill Road, Conowingo, Maryland 21918 Timothy N. Toncic (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State West Chester. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If ony injury or once. R.A.Ferris & Co., Inc. 09/18/10 Pennsylvania Lee A. Partyville, 21. Signafure of Funeral Service License & Son Funeral Home 0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alcoholic CIZQUOSIS YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a so iseque) se of) use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy Year Month Day 5 Other (specify) 4 Pregnant at time of death this certificate has been signed by the and director, page 2 should be detached to 1 Yes 2 No 9□ Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performe 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 TI Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. å 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0056296 9-16-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Birnbaum. M.D.. 602 South Atwood Road. Suite 206. Bel Air. Maryland

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Medic		4a F:	Mary acility Name (if not institutio	n, give str	eet and numbe)				Location of				ounty of Deat	h	
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than "dic I Examiner must be notified at the Medic I Examiner must be notified at	Funeral		209 Mars	h Ay	7			21	562	lianania Or	rigin2 (Spe	cify Yes or No		4. Race - Ame	erican Indian,	
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Maryland	Ild be I Men narke natic	-	-	Lesley Mi a. Informant's Name/Relatio				19b.	Mailing Addres	ss (Street					Town, State, Z	ip Code)	
Mar	th and			Harry Taylo		Husba	nd		09 Mar			West	ternpo	rt,	MD. 2	<u> 1562 </u>	
	Healt Healt tem 2			Method of Disposition			2	Oh Diego of	Disposition (Na , crematory or	ame of			Date	20c. Lo	cation - City o	or Town, State	
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 20a or 28a-f show important: If item 27 is marked other than "natural", or items to or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21.	. Signature of Funeral Service									edlock				
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C	Medica Examine	-	re	sulting in death)		Due to (d	r as a co	onsequence o	1).								
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P.O. Box 68760	ath certificate be executed attending physician and for use as the burial-transit	Completed by Physician/Medic	IF	FEMALE:		23c. If yes, out	come of	pregnancy							23d. Date of	delivery	
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ior	death death stor: /			3 ☐ Suicide 6 ☐ C	vestigatio could not l etermined	be 28e Place	of Injury	/ - At home, f	arm, street, fac	ctory, offic	се		28f. Location	on (Street a	ind Number of te)	r Rural Route N	lumber,
Division of Vital Records,	lor A after Direction			4 El Homoldo		Dalla	ing, etc.						1	-(-)		s stated	
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur	000	Medical	29a. Certifier 1 Cert	ifying Phylical Evan	ysician: To the niner: On the ba	best of m	ny knowledge amination and	, death occure or investigation	d at the t n, in my o	time, date pinion, dea	and place ath occurre	and due to the	e cause(s) ate and pla	and manner a ce, and due to e(s) and manne	the cause(s) an er as stated.	d manner state
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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend Item 25 per med cert 6908 10/1/10 dk
State of Maryland / Department of Health and Mental Hygiene 20 10 31059 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Tyrone Taylor 2010 1:48 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 579-94-5692 Days Hours 1 27 187 1960 Country) Director DC Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 8600 16th St #1109 U.S.A. 20910 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No or Black, White, etc. Completed by 1 Never Married 2 😾 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Black "natural", 3 Divorced Specify: permit. Page 1 and 2 should be filed within 72 hours bepartment of health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I-ant: If item 27 is marked o ပ္ Richard Lawrence Mack Perquita Taylor 19a. Informant's Name/Relationship (Type, Print) Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Lanham La.
Washington, MD 20744 Britania P. Taylor - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Cemetary 8/23/2010 Waldorf, MD 22. Name and Address of Facility DL McLaughlin Funeral Home 2019 MLK Jr Ave SE, Washington DC 20020 Signature of Juneral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last for use as the burial-tran Due to (or as a po been signed by the attending physician should be detached for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ည 1 🗌 Yes 2 😿 No Other: 1/X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending iniury Investigation 6 Could not be within 24 hours after deatl To the Funeral Director. Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the pasts of examination arror investigation, in his opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur and title of certifier 29c. License number 2010 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month 18^{Day} Physician/ James Ostell Warren 20To 2:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3638 Grosvenor Drive Ellicott City Howard ocial Secunty Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday If Under 24 Hrs **Funeral** 237-46-6217 Months 80 972371929 **Director** NC Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits traun atic event, the Medical Examiner must be notified at Director or 28a-f 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 3638 Grosvenor Drive 21042 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ò <u>ک</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates. "natural", 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Fork Lift Operator Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be filed and Mental H Oscar G. Warren ည Lela Honeycutt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Dorothy Warren - Wife 3638 Grosvenor Drive Ellicott City, MD 21042 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/22/2010 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. In 21. Signature of Funeral Service Licensee all = - WhytyM01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Anaplastic Large Cell Lymphoma of chest Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by Anorexia-Cachexia Anemia Records, 1 🔲 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy page To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page completed filled in by the funeral director, page 1 Tes 2 🗌 No 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 4No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending Division 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 305 9-20-10 CIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Minford, 10710 Charter Dr. Suite G020, Columbia, MD 21044 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GEORGE E. WILSON SEPTEMBER 4:15 PM 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR EASTON TALBOT Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min MAY 9 WEST VIRGINIA Director 321-28-1675 90 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 □ No TALBOT **EASTON** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 DUTCHMANS LANE 21601 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 X Widowed 4 □ Divorced Year or Dates if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည JESSIE H. WILSON EFFIE FISCHER .. Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN FUNK, FRIEND 173 LEHMAN DRIVE, YORK, PA 17403-5122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION: 9/14/2010 STEVENSVILLE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
200 SOUTH HARRISON STREET, EASTON, MD 216 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ģ Dav Year Pregnant at time of death 2 🗌 No the g Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but/not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy this certificate 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🖵 ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending ☐ Accident☐ Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ, 508 IDLEWILD AVENUE, EASTON, MD 7+VA 21601 31. Date filed (Month, Day, Year) SEP 13 2010 State Registrar's Sig Registrar

DHMH 17 Rev 1/2001

State Registrar

10

30. Name and address of person who com David H. Smith,

31. Date filed (Month, Day, Year) **SEP 15 2010**

ed cause of death (Item 23a) (Type, Print)

M.D.

32 Aegistrar's Signatur

D39887

8221 Teal Drive, Suite301, Easton, MD 21601

9-13-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death SEPTEMBER 27, Physician/ 2010 WILSON 1:35 P BEVERLY ANN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Min (Month, Day, Year) 9/30/1930 1 M 2 X X 212-28-5784 79 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tent. If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3126 Whiteford Rd Pylesville Harford 1 🗆 Yes 2 🛮 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21160 3126 Whiteford Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 Mo If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) bwn home Elementary/Seconday (0-12) College (1-4 or 5+) homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy VonderSmith <u>Barry Joseph Plun</u>kett 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State Tip Code)
21700 Glendalough Rd. Laytons VIII (2008)
MD 20882 19a. Informant's Name/Relationship (Type, Print) William B. Wilson- son permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Highland Cemetery 10/1/2010 Street, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harkins FH Inc., Delta, PA 17314 Signature of Finery Service Licens 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1. Enter the disease, scomplications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician endsta disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ause (Disease of linjury To the Hospitallor Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy rate has been signed by the atterpage 2 should be detached for u in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Yes funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work fter decth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 03 2295 Stylenber 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR, MD. 21014 MACPHAIL ROAD DAVID DUNN 615 W. Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per FH G908 10/20/10 dk
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 15 2010 02:09 PM Billy Brown Wright 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

7. Age (In yrs. last birthday)

10c. City, Town or Location

North East

Days

If Under 1 Year If Under 24 Hrs.

Hours

Ceci1

9. Birthplace (State or Foreign CountryRock West Virginia

10d. Inside City Limits

1 Yes 2 No

8. Date of Birth
(Month, Day, Year)
July 5, 1938

Physician/ Medical Examiner **Funeral** Director should be filed within 72 hours after death with the Maryland

- State Registrar

Social Security Number

236-54-7263 Usual Residence of Decedent

10a. State

426 Champlain Road

10b. County

Ceci]

1**XX**M 2 □ F

if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Funeral Director Maryland North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 426 Champlain Road United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2XXNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2XX No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Meadows Clarence B. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is P.O. Box 217, North East, Maryland Beatrice Wright / Spouse permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of Osburn Family) or other place) Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 75 🗀 Other (Specify) Webster Springs, West Virginia September Signature of South 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Fusult Rem Q Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a confequence of): The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 Yes 2 No Physician; of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Hospital or Attending Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation after death Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opiniori, dean occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number m Har MD 104823 ceil. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HSU. 223 West main &to HIHD IUT MD 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 9/17/10, M.S. Kent Co. Registrar Amended #18 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 09 8:50AM Whittington Jr. Hughes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oueen Anne's Centreville Hospice of Queen Anne's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Hours Min. Country) Mary Land Director 80 221-18-3117 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits Director 10c, City, Town or Location 1 Yes 2 No MD Kent Galena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 W. Cross Street Apt. D-4 USA 21635 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White etc. ğ 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housing 12 Maintenance 18. Mother's Name (First, Middle, Maiden Surname) Wilson Be 17. Father's Name (First, Middle, Last) ၉ Ella Virginia Whittington Huges Whittington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Hudson - Daughter Bridgewater Dr. Rowlette, Texas 75088 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Memorial 09/24/2010 Bear, Delaware 21. Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam Kup of 130 Speer Road Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or complic flors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Securatelly list out littles if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death cerlificate be executed attending physician and Due to (or as a cons P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death Month 5 Other (specify) Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🗡 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate has performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1X Natural 28c. Injury at work? 1
Yes 28b. Time of 28d. Describe how injury occurred 5 \square Pending

Division of Vital Records, 24 hours after death. Funeral Director: After this

within 2 To the F

State Registrar

DHMH 17 Rev 7/2009

Vasir 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Accident

Suicide

4 Homicide

29a. Certifier

(Check

only one 29b. Signature and title of c 2 🗌 No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Marylar		artment of H		d Mental Hy	giene	010	3100	56
			Registrar 1. Decedent's Name (First, Middle	(act)		Cer	tificate of D	eath	T. 5	Reg. No.			
	Physicia		Roberta		ouise		Woode	n	2. Date of De Month	Dav	Year	3. Time of De	ath M
	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, or		- 09 - ath	26 40.00	2010 ounty of Death	1,001	141
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Т	Funeral		5. Social Security Numbler	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Unider 24 F		th	9. Birth	lace (State or Fo	reign
	Director		499-52-2532	1 □ M 2 XX F	63	Yrs.	Months Days	Hours M	in. 047/05	1947	Miss	Souri	
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99	after o		1 Never Married XX Marr	ied 1 Yes			Yes XX No		erto Ricari, etc.)	Sn	Black, White, ecify: White		
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Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Mayland it of Health and Mentlar Hygiene. 14 for Health and Mentlar Hygiene. 15 fem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	မ	Walter			arten		Hele	en 		Brook		
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nor.	Page 1 ment of 1 tant: If it ury or o		1 ☐ Burial ②X Cremation 4 ☐ Donation 5 ☐ Other (S		State Hag	emetery, cremers town	natory or other place n Cremato	rv 9/2	Date 27/2010		stown,		
Baltimore,	permit. Page 1 Department of Important: If i any injury or o	- 0	21 Signature of Funeral Service L	**	1 -						T		
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Jane J.	Medical Examiner		resulting in death)	Due to (c	or as a consequ	ience of):	PATH	-		я.			
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6876	ng phy as th	Med	IF FEMALE:										
9 X	tendir rr use	ian/	23b. Was decedent pregnant in the past 12 points?	23c. If yes, outo	ome of pregna Birth 2 🗌 Feta	l death 3	Ectopic pregnancy	,		23d	I. Date of delive	*	
Box	the at	Physician/Me	1 Yes 2 No	4 ☐ Pregn 9 ☐ Unkno	ant at time of c own	leath 5 L	Other (specify)				Month	Day Year	
Records, P.O.	requires that the death certifics been signed by the attending p should be detached for use as it	/ Ph	Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use	contribute to th	e cause of death	1?
S, T	signe Id be	d by							1 🗆	Yes a	> No 3 ☐ Prob	ably 4 🗌 Unk	nown
ord	shoul	lete							24a. Was	an 2	4b. Were autor	sy findings avail	able
Vital Records,	r this certificate has by	Completed								rmed	death?	npletion of caus	e of
<u>a</u>	rtifica ttor, p	Be C	25. Was case referred to medical	11			26. Pla	ce of Death (C	1 \(\text{Yes} \)	2□ No	1 🗆 Yes	2/S-NO	
VIC	nis ce direc	To E	examiner?	Hospital;	npatient 2 🗆	ER/Outpatien	t 3 DOA Other	4 Nursing	g Home 5 🗆 Resi	dence 6	Other (Specify)	Hospic	12
o a	After th		27. Manner of Death 1	28a. Date o	f injury n, Day, Year)	28b. Time of injury	28c. Injury work?		28d. Describe	now injury oc	curred		
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DIVISION OF	after Direc	Cer	4 Homicide determi	28f. Location (S City or Tov		ımber or Rural	Route Number,						
	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	ical	29a. Certifier Certifying	Physician: To the be	st of my knowl	edge, death o	ccured at the time,	date and place	e, and due to the ca	use(s) and m	anner as state	d.	
F.	in 24 l	Medical	(Check / 2 L Medical E	kaminer: On the basis Nurse Practioner: To	of examination	and/or invest	igation, in my opinior	, death occurre	ed at the time, date a	and place, and	d due to the cau	se(s) and manner	rstated
10	with Coa		29b. Signature and title of certifier				29c. License	number		29d. Date si	gned (Month, £	Day, Year)	
							000	2584	10	9	126/4	<u> </u>	
			30. Name and address of person v	ho completed cause	of death (Item	23a) (Type, P	rint)	9584 98m		. 0 -	7 151:		
	CAL		31. Date filed (Month, Day, Year)	20 80	gister's Signat	177	3 540	you	ug u	(1)	0180	_	
	Stat Registra		OCT 0 4 2010	Derous .	1. 4	Tike							

DHMH 17 Rev 7/2009

Roberta L. Wooden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 14 2010 Physician/ September 4:55 Рм Wells Windland Elizabeth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Genesis Healthcare Spa Creek Center <u>Annapolis</u> Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Hours 09-18-1913 Mary Tand Director 218-42-0343 96 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 35 Milkshake Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Year or Dates white Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur ury or other traumatic event, the Medical] ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 10 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Tell Wells Lillian Daugherty Percy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh E. Windland, Jr., 6941 Prout Road, Friendship. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friendship Cemetery 09-18-2010 Friendship, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Unidentify Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of). resulting in death) Last completed filled in by the funeral director, page 2 should be detached for נוגא איייים ביייים ompleted filled in by the funeral director, page 2 should be detached for נוגא אייים איי Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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within 2 To the

State Registrar (Check

only one)

Name and address of pe

who completed cause of death (Item 23a) (Type, Print)

Registra Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December Processing Services		-	For State Registrar		Š	state of	Iviaryia			rtment of F ificate of D			ientai Hy	/giene Reg. No	211	0	3100	68
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By Hard Board of the Control of the									~//			Min,	(Month, D	av Year)	1928	Count	rv)	ireigii
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Female Check only one) Female Check only one) Female Check only one) Female Check only one) Check one Chec	/		resulting in death)		~ -	Due to (or	as a conse	quence of):		1	2	0:		1)		9	
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12tiva John A-Shuttam.D., Pu Bux 310, Walker's ville, Md 21793 State 31. Date filed (Month, Day, Year) 32. Register's Signature	To th To th		29b. Signature and t	title of certifier	mo), afte	nling	physi	hi			20		-	te signed (-		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	12tIVA		30. Name and addre						-		vill	e. W	1d 2	179	3			
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylar		artment <i>tificate</i>			ınd M	lental Hy	giene Reg. Na	2011	3106	9
	Physicia		Decedent's Name (First, Middle,	Last) Sarah	Vahhe			<u> </u>			2. Date of Dea	ath		3. Time of Death 12:05pm	1
	Medic Examin		4a. Facility Name (if not institution, s		iber)		4b. City, To		ocation of		<u>Septem</u>		4c. County of Death Montgomery		
	Funeral Director		5. Social Security Number 578-24-5773		7. Age (In yrs. 8	-	If Under 1 Months		If Under 2 Hours		8. Date of Birt Month, Day		g. Bir	thplace (State or Foreign untry) hungton, D(2
	aryland a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Monto	jomery	10c. Ci	ty, Town or Loc	cation	D	ockvi					10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	with the M 23a or 28 ist be noti	Funeral Director	10e. Street and Number 6121 Mont	-			10f. Zip C	Code	20852	<u>ue</u>		10g. Ci	tizen of What Co		
36	Defailt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 Marrie	12. Was Dece	dent Ever in U. rces? 2 😿 No	11	Vas Deceder Yes, specify	nt of Hisp / Cuban,	oanic Origi Mexican,	in? (Spec Pu e rto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:	rican Indian, e, etc.	
Maryland 21215-0036	n "natural Medical Ex	Completed by	3 🗓 Widowed 4 ☐ Divorced 15. Decedent (Specify only highest	Year or Da 's Education t grade completed)	ites.	16a. Deced	ent's Usual (kind of work (D NOT use re	Occupati	ion	of workir	ng	16b. K	Gind of Business	White	
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Baltimore,	Definit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral S	ecify)	Mt.	24 22	. Name and	Address	of Facility	Hine	s-Rinal	ldi		Home, Inc.	
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ار بن اسمان	Physician Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (PD Exac	uence of):		_						Onset and Death	_
	ted Insit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Respiratory Failure cause (Disease or injury that initiated events c. Failure to Thrive												
09	ate be executed oblysician and the rial-transit	dical Ex	that initiated events resulting in death) Last	Due to (or as a consequence of the conse	uence of):	η:								
P.O. Box 687	the attending phed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Birth 2 Feta nant at time of	al death 3 🗌	Ectopic pre	egnancy cify)					23d. Date of del Month	ivery Day Year	
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D	550		29b. Signature and title of certifier		SHAN			D65					te signed (Month	, Day, Year)	
	V		30. Name and address of person who Sudarshan Siva,	MD. 860	0 Old (Georget	own Ro	oad,	Beth	resd	a, Mary	lanı	d 20814		
	Stat Registra		31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>)	10 Pert	egistrar's Signa	face	J.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 19,201 Mary Paulette Young 5:11PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SAINT JOSEPH MEDICAL CENTER BALTIMORE TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year)
July 25, 1942 Days Hours Min 1 🗆 M 2 🗶 F 038-26-9842 68 Director Maryland Usual Residence of Decedent Show 10a. State 10b. County filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11 West Baltimore St. Apt. 324 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Completed by Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Housekeeper other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Irene Marie Miller Leonard Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 East Baltimore St. Funkstown, MD William C. Moreland - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sept.22,2010 Williamsport, Maryland 4 Donation 5 Other (Specify Greenlawn Mem. Park Osborne Afanerality Home, P.A. Siturature of Fi 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death Physician, RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). sician and burial-transit CONGESTIVE HEART FAILURE the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? eral Director: After this certificate I filled in by the funeral director, page 1 ☐ Yes 2 🗶 No Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 🛛 No Other: မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifie 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) D 31826 LUIF NICHE 70-10

3 State

Registra

RICHARD

31. Date filed (Month, Day Year)

L.

7601 OSLER DRIVE.

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINTHICUM.M.D

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State 9-28-10cr State 9-28-10cr Registra Amend #17.19a. PerInformant PGC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2010 Year Physician/ Sept. 14. 4:37a. M Young С. Frederick Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES MITCHELLVILLE VILLA ROSA NURSING HOME Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 8/3/19] Director 578-01-8590 SHINGTON. 95 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGES COLLEGE PARK 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6100 WESTCHESTER PARK DRIVE 20740 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Yes 2 No If Yes, Give 1 Never Married 2 Married 1 Yes 21 No Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>yrs</u> POSTAL WORKER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည YOUNG WILLIAM -S POLLY DEANE 19a. Informant's Name/Relationship (Type, Print)
Wilson
LINDA D. WILLSON/ DA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11107 QUEENS WOOD TERR. BOWIE MD 20721 DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🖳 Burial 2 🗌 Cremation 3 🗌 Remo 4 Dopatjon 5 Other (Specify ARLINGTON NATIONAL 12/30/2010 ARLINGTON, VA S atur of Funeral Service ensee 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC 12th ST. NE WASHINGTON, DC 20017 3005 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition resulting in death) Disectse oronary Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy performed Fa hrive clure Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 4 No ြုင 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 005333 15

Registrar

State

Anenue

203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP 2 0 2010

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 09/08 10:07 P James Brodale Zorn, Sr 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery

9. Birthplace (State or Foreign Country)
Country)
MN Collingswood Nursing & Rehab Center If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 1 € M 2 □ F Months Days Hours Min Director 484-20-8219 04/10/28 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 🗆 Yes 2 😾 No Montgomery Clarksburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 22909 Timber Creek 20874 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) /1 Government Nuclear Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clyde Zorn Sarah Brodale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timber Creek Lane, Clarksburg, MD 20874 James B. Zorn, Jr./son 22909 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 20c. Location - City or Town, State Date M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 09/24/10 Humboldt, Iowa Signature of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home.P.A. 46 N. Washington St. Rockville. 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death e, or compli ions that caused the death. D not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only Immediate Cause (Final Physician/ woyche 119 disease or condition resulting in death) Medical Due to (or as a consequence of) Examine BENEENSICK Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law equires that the death certificate be executed Cause (Disease or imjury VENTOVO that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical etes cusills M 196 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by reid 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier and 29c. License number 29d. Date signed (Month. Day, Year) Scotember 92010 DAILES LAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Year)

SEP 17

Doctori Drix

Germanteun mp 20874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 8:15 AM M September 17, 2010 Emma M. Allen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 25, 9. Birthplace (State or Foreign (In yrs. last birthday, **Funeral** Days Mary Tand Hours Year) 925 1 □ M 2 🖫 F 84 Yrs 212-20-8772 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. M. Closl Evaruinat into the notified at 10c. City, Town or Location 10d Inside City Limits 10a. State 1 ☐ Yes 2 📆 No Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 408 Lee Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ∐ Yes 27∏ No Specify: Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 financial accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susie Crismer Ferdinand McAvoy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 211 Brookside Drive Catonsville, MD 21228 19a. Informant's Name/Relationship (Type. Print) Jason Coppola/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∑Donation 5 ☐ Other (Specify) Funeral Service Licensee Ronald So Wade 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 655 W. Baltimore Street Director Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5 years coronary artery disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day fo 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached 9 Unknown icate has been signed 7, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò congestive heart failure 3 Probably 4 Unknown 1 🗌 Yes 2 7 No Completed chronic atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No debility 25 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D56531 Sept 28, 2010

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li MD 8600 Snowden River Pkwy #301 Columbia, MD

Please	Type or Print in Black Indelible Ink.	Ensure All Copies Are	Legible./	0 31	1
	State of Maryland / Department of H				

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Funeral.			6. S ex	7. Age (In yrs. last bi	irthday)	If Under 1 Ye	ar If Und	ler 24Hrs.	8. Date of Birt	h(MM/DD/	YYYY)	9. Birth	place (State or
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15-(17. Father's Name (First, Middle, Bonzell Amos	Last)					18.Mothe Kath	rs Name (F lerin	irst, Middle, M e Wat	kins	name)		
and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. Health and Mental Hygiene from 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	— ∟	19a. Informant's Name/Relationsh	nip (Type, Pri	int)	19	9b. Mailing	Address (Stre	eet and Nur	mber or Rur	ral Route Num	ber, City o	r Town,	State,	Zip Code)
AD 2 sho h and 27 is	-	Barry Amos Ji	-So	n	5	202	Pembro	oke A	Ave,	Balti	more	, 1	1d	21216
Te, Te, I and I and Healt Fitem		20a. Method of Disposition			1	of Disposit	ion (Name of c	emetery,	10/1	Pate 20c. Location - City or Town, State				
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	П	21. Signature of Funeral Se Lice ee 2. Name and Address of Facility arch F/H West												
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Box 68 e death certif the attending ed for use as	Physician/	1 Yes 2 No 9 Unkr	nown 9	Unknown										
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Vital Records, ysician: The law requirements in sertificate has been signeror, page 2 should	24a. Was an autopsy prior to completion of car death? 1 Ves 2 No 1 Ves 2							2 No						
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f Vi Physi	의	1 ✓ Yes 2 No 27. Manner of Death		1 Inpatient Date of Injury		Outpatient Time of Inj			Nursing F		Residence		Other:	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the are after death. The rector: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 9-25-10 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No unknown													
ivision or Attence after death Director:	27. Manner of Death Natural 5							al Route Number, City						
Div ital or rral Di	28a. Place of Injury - At home, farm, street, factory, office building, etc. 29a. Value of Injury - At home, farm, street, factory, office building, etc. 29a. Value of Injury - At home, farm, street, factory, office building, etc. 29a. Value of Injury - At home, farm, street, factory, office building, etc. 29a. Value of Injury - At home, farm, street, factory, office building, etc. 29a. Value of Injury - At home, farm, street, factory, office building, etc. 29a. Value of Injury - At home, farm, street, factory, office building, etc. 29a. Value of Injury - At home, farm, street, factory, office building, etc. 29b. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Injury - At home, farm, street, factory, office building, etc. 29c. Value of Inju							alto. Md.						
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction of t	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	Σ	29b. Signature and title of certifier	0/1	-01	1/1/	200	†	M F						h, Day, Year)
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		 Name and address of person victor Weedn MD JD 		ed cause of dea nt Medical E		111 Pe	nn Street,	Baltimor	e, MD 21	1201				
Sta		31, Date filed (Month Day Year)	1	32. Registrar's	Signature									
Registra	ar	001 0 5 2010	Cenny	1 B.	park			_						-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALIBERTI ELIZABETH SEPTEMBER 28 2010 6:38 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 🔀 F (Month, Day, Months Hours Min. Director 219-52-9936 65 Maryland Usual Residence of Decedent 28a-f shov 10a. State be notified at 10c. City. Town or Location 10d. Inside City Limits Director Md Baltimore Randallstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a the Medical Examiner must b Funeral 8816 Stonehaven Road 21133 U.S.A. hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16b. Kind of Business Industry
Baltimore City 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public School Syst Teacher Vocal Music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ James Knozek Elizabeth Zygmunt permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) husband Rocco A. Aliberti 8816 Stonehaven Road Randallstown, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State injury or 4 Donation 5 Other (Specify) Lorraine Park Cem, Oct. 1, 10 Baltimore, Md. 21. Signature of Funeral Service Liversee 22. Name and Address of Facility Joseph N. Zannino Jr. harl, 263 S. Conkling St. Balto. Md. 21224 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only on extions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Immediate Cause (Final Onset and Death Physiciani SEPTIC disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** URINARY INFECTION Sequentially list conditions, Examine cause. Enter Underlying physician and s the burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed KIDNEY STONE Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death 9 Unknown ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law page 2 autopsy perforn certificate 1 🗌 Yes 2 📉 c Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA မ this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 🗌 Yes 2 🗆 No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 Certifying No only one) 29d. Date signed (Month, Day, Year) D0060293 SEPTEMBER 28 2010 cause of death (Item 23a) (Type, Print) OLD COURT RD. RANDALLSTOWN MD 540 , M.D State

DHMH 17 Rev 7/2009

Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 5 2010

ORIGINAL

D0053150

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakunmale

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2010 2:30p 0ct Bader Joseph James Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dundalk <u>7130 Crestshire Road</u> 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Feb. 8, 1914 Maryland 1 🛣 M 2 🗆 F Months Hours Director 96 213-05-1465 Usual Residence of Decedent "natural", or items 23a or 28a-f show s Itcal Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2X No Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7130 Crestshire Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 \times Yes 2 \times No 1942 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11, Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 1945 3 Widowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 hour if Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Me Ical. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Office Worker Lumbervard Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Schane George J. Bader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Kielman, Sister Osborne Avenue, Catonsville, Maryland 21228 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 10/4/2010 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of uneral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Diabete Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death been signed by the should be detached q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 9 Hospital or Attending Physiclan: The law requires to 24 hours after death.
2 Funeral Director: After this certificate has been sign. 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s death? 1 ☐ Yes 2 ☐ No Ves 2 NO 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R125808 Long 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , CRMP 6701 N. Charles St

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Cage Beahm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Square H050, ta ranklin 9. Birthplace (State or Foreign If Unde 8. Date of Birth In yrs. last birthday) **Funeral** Year) 2010 Sept 28, Hours 2 1 🕅 M 2 🗆 F Maryland Director infant Usual Residence of Decedent 28a-f show 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2x ☐ No MD Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Water Watch Court 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Penny Hedgins Woodrow Kenneth Beahm Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9000 Franklin Square Drive Rosedale, MD 21237 Franklin Square Hospital Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 □ Donation & M Other (Specify) in state 21. Signature of Fun. - | Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Ronald Baltimore, MD 21201 ter the mode of dying, such as cardiac or respiratory arrest Part Nenter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) atu Due to (or as a consequence of): Medical **Examiner** Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury 0 ce $n + \alpha$ that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Year Month Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No ned by the a g 🗌 Unknown has been signed by it also be a should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 🗌 Yes 2 🗎 No After this certificate ! completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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Physicia /Medic		1. Decedent's Name (First, Middle Melvin Leona	ard Bright					2. Date of Death Month September	Day 27, 2		
Examin	er	4a. Facility Name (If not institution 3205 Woodsid		mber)		4b. City, Town, or Location of Death Baltimore			4c. County of Death Baltimore		
Funeral Director		5. Social Security Numberunk 214-50-8610	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 18,	Year) 1947 N	9. Birthplace (State or Foreign Country) Maryland	
show	ō	Usual Residence of Decedent	imore		Town or Lo					10d. Inside City Limits 1 □ Yes 2♥ No	
vith the M s or 28a-f	Direct	10e. Street and Number			Balti	10f. Zip Code		10	g. Citizen of Wh		
urs after death v sl", or items 238 yaminer must	by Funeral Director	3205 Woodside 11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed For 1 □ Yes	2 X No ∕e		212 Was Decedent of H f Yes, specify Cuba	234 ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. black	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examinat must be notified at once.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12	ot's Education set grade completed) College (1		(Give life. l	dent's Usual Occup kind of work done of DO NOT use retired Esperson	during most of work	ing	6b. Kind of Busi	ness/Industry	
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1 and 2 s Health ar em 27 is		Melvin Bright 20a. Method of Disposition			2503	•	venue #80	9S Balti	more, M		
nit. Pages artment of ortant: If it injury or o		1 ■ Burial 2 □ Cremation 4 □ Donation SHOther (C	ipcoify) in	State cen	netery, cren r butu :	natory or other plac s Mem. Pk	e) !	3-10 A	rbutus,	Md	
Impo my any once		Renald	S. Wiley D	irector	- B	altimore	, MD 212	01 21223	2700 E	dmondson Ave.	
Physician /Medical		23a. Part 1. Enter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)	- Atte	MIOSC)	erat		dio vas	1 3	019205	Approximate Interval Between Onset and Death	
Examiner	er	Sequentially list conditions.	b	or as a conseque			·				
ate be executed hysician and he burial-transit	lical Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequer	nce of):						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregnanc birth 2 Fetal di nant at time of dea own	eath 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont		
quires tha		Part II. Other significant condition	ons contributing to de	eath but not resulti	ng in the ur	nderlying cause giv	en in Part I.	23e. Did toba		oute to the cause of death?	
r: The law re icate has been page 2 sho	Completed by					2.0		24a. Was an autopsy perform 1 □ Yes 2	ed? pri	ere autopsy findings available or to completion of cause of ath? □Yes 2 MNo	
hysician his certif	To Be	25. Was case referred to medica examiner? 1 XYes 2 □ No	Hospital:	npatient 2□EF	₹/Outpatier	nt 3 □ DOA Oth	or·	th <i>(Ch</i> ec <i>k only</i> o <i>n</i> e ome 5 ≰ Resider		(Specify)	
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pital or A		4 ☐ Homicide determ 29a. Certifier 1 ☐ Certifyin	buildir	ng, etc. (Specify)			me date and place	City or Town,	State)	or Rural Route Number,	
the Hos	Medical	(Check only one) 2 Medical	and manr	asis of examinationer stated.	n and/or in	vestigation, in my o	ppinion, death occu	rred at the time, da	te and place, an	d due to the cause(s)	
To Your	-	29b. Signature and itile of certifie	MD [Deputy	(20) /Time	29c. Licens	8667	S.	eptemk	2010 2093	
· · · · · · · · · · · · · · · · · · ·	- 1	30. Name and address of nerson		e or deam memo		Print)					
Sta		30. Name and address of person Philip Mili 31. Date filed (Morth, Day, Year)	+ - 1 0 A	e of death (fleffiz	Trim	ole Hil	1 CTLut	hero:11	e M	21093	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ Bagrowski Jr. 2010 19:20 \mathbf{P}^{M} Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Abingdon 200 Oak Leaf Circle Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) (Month, Day, **Funeral** Hours Min. 1 ▼ M 2 □ F 1953 Maryland **Director** 217-50-1936 57 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Adbingdon Harford Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 21009 200 Oak Leaf Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11 Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Specify: Completed 3 ☐ Widowed 4 😾 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Transportation Authority Police Officer 4 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Olszewski Joseph Bagrowski Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 1700 Bayard Avenue, Dundalk, Maryland daughter Jessica Lynn Bagrowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland Cardens of Faith Cemetery 7, 2010 21. Si natire of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. non 23a. Part 1. Enter the disease, or complications that caused the doubt. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line SUDDEN Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician ca Division of Vital Records, P.O. Box 68760 Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate has P No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 7 10 completed filled in by the funeral director, 26. Place of Death (Check only one) Be ုင 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manger of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 24 hours after death Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours a Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 10036951 30. Name and add who completed cause of death (Item 23a) (Type, Print) 9114 Philadepphiz Rd, Suite 158 chluederberg State 0 5 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 0 3 1 0 8 1 State of Maryland / Department of Health and Mental Hygiene

Barbara Ellen B	ohln	nan 1- For State	State of Mary	•	rtment of		nd Mental I		201	0 31001
Physici	an/	1. Decedent's Name (First, I	, ,		•	Dodin		2. Date of Dea Month	eg. No. th Day Year	3. Time of Death
Medical Exami	iner	BARBARA 4a. Facility Name (if not inst	Ellen	Bohlm		City Town	or Location of Dea	October 1	, 2010	1805 hrs
)		1620 Concordia D		number)		Pasadena			Anne Aru	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye				8. 8irthplace (State or Foreign
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leath with the Maryland items 23a or 28a-f show ust be notified at once,	Director	10e. Street and Number 1620 Conce	PROCA I	RIVE		10f. Zip Code	1122	'	0g. Citizen of Wha	S-A.
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)36 thin 72 ho ie. than "na edical Es	piete	Elementary/Secondary (0	-12) College	(1-4 or 5+)		et of working lift	ie. DO NOT use re	etired)	RIL	to Country Schools
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menlal Hygiene. Titem 27 is marked other than "natural", or items 23a or 28a-f sho not in If item 27 is marked other than "natural", or items 23a or 28a-f sho not other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Rela		SON SON	19b. Mailing .	Address (Stre	eet and Number/or	Rural Route Nun	hber, City or Town,	State, Zip Code)
ore, ME es 1 and 2 s of Health au If item 27		20a. Method of Disposition 1 Burial 2 Crem		CIO	ematory or othe	r place)				is Md 21409 City or Town, State
imo Pages ment of tant: 1 or oth		4 Donation 5 Othe	er Specify:	War State	est A	undel	Cren. 10	-5-2010	Odente	N. MATYLAND
Baltimo permit. Page Department of Important: injury or ott		21. Signature of Funeral Ser	vice Licensee	,	22. Na	me and Addres	ss of Facility	osept	Rally 1	N, MATYLAND MNO JRFH. Yd 21224
Physician		23a. Part I. Enter the dise		t caused the death. [Do not enter the	mode of dying	g, such as cardiac	or respiratory arro	est, shock, or hear	t Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Fin a se or condition resulting in dea	ease a. Cirr	hosis of						Death
		Sequentially list conditions.	b	s a consequence of):						
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ited d ansit	Exan	(Disease or injury that initiat events resulting in death) L		s a consequence of):						
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	ian/Me	IF FEMALE: 23b. Was decedent pregnant	in the	s, outcome of pregna		I death 3	Ectopic pregr	nancy	23d. Date of d Month	elivery Day Year
OX 6 ath cert attendii	Si	past 12 months?	Helice and	gnant at time of deat	, - H	(Specify)		-		
O. B.	Phy	Part II. Other significant co	9 0116	to death but not res	ulting in the un	derlying cause	given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
Division of Vital Records, P.O. also or attending Physician: The law requires that the star death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	ed by								2 No 3	
cord law req has bee 2 shou	ompleted							24a. Was autop	sy pri	ere autopsy findings available or to completion of cause of ath?
Rec : The liftcate or, page	ပ	25. Was case referred to me	dical			26 Plan	e of Death (Check	1 🗸 Yes		Yes 2 No
Vital I ysician: this certifi director,	o Be	examiner?	Hospital: 1	Inpatient 2 E	R/Outpatient		Other		Residence 6	Other: Scene
n of Viding Physi	On: T	27. Manner of Death 1 X Natural 5		te of Injury 2 hth, Day,Year)	28b. Time of Inj		ury at Work?	28d. Describe	now injury occurred	1
ivisior or Attend after death Director:	ertification:	2 Accident	Pending Investigation 28e. Pla	ace of Injury - At hom	ne, farm, street,		Yes 2 No	28f. Location (S	Street and Number	or Rural Route Number, City
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Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b			ng Physician: To the be Examiner: On the basis							
Tot with Tot	Medical	29b. Signature and title of ce	and manner	stated.			se number			(Month, Day, Year)
		Menjorie	The Ja	ile		0.0	.M.E.		October 2, 2	010
Hold		30. Name and address of pe		use of death (Item 2)	•	nn Street. E	Baltimore, MD	21201		
St	ate	31. Date filed (Month Car Y		Registrar's Signature		/				
Regist	rar	001 001	-010	h. 6	7 4 4 7 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 50p M **Physician** /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number Examiner 2100 0 Birthplace (State or Foreign Country) If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 302-26-3220 Kentucky Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c, City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Ohio Franklin Worthington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 43085 422 East Clearview Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: ģ Specify: White 3√ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Learnit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than "ne any injury or other traumatic over-Elementary/Secondary (0-12) College (1-4or 5+) Telemarketer Sales 12 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Anna Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29379 Corbin Parkway, Easton, Maryland 21601 Michael Callahan Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9 - 30 - 10Wellston, Ohio SalemCemetery 22. Name and Address of Facility 21. Signature of Funeral Service Marzullo Funeral Chapel, P. A mulace 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Urinary)ays ection **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** evovesical Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on law requires that the death certificate be executed cancer ome sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4 Pregnant at time of death 5 Other (specify) signed by the a be detached for Ö ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s Hospital or Attending Physician: The performe certificate 2×100 1 ☐ Yes 2.⊠No 1 ☐ Yes Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospice Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 of this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. WASHINGTON ST LAKSHMI VAIDYANATHAN EASTON

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 0 5 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** William A. Corcoran September 2010 9:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8415 Bellona Lane #314 Balt<u>imore</u> Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 1, 1939 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Months 1**X** M 2□ F 71 Maryland Director 212-32-8950 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evaninations to confer traumatic event, the Medical Evaninations to confer the property of the Medical Evaninations to confer the month of the Medical Evaninations. 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8415 Bellona Lane #314 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 [ZYes 2 □ No If Yes, Give Year or Dates: • 60— 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify: Specify: white **'**60-68 ģ 3 ☐ Widowed 4 🖾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) advertising agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be J. Neil COrcoran Bess Daily ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1904 Lindemann Lane Lutherville, MD Lindley Corcoran/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Signature of Funeral Service Licensee Ronald S. Wade, , Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death stroke Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) veolar Cancer Examiner vonchio al Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ FI 1 V Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) Batimore Mace. anony 31. Date filed (Month, Day, Year) OCT 0 5 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a Per Phy G908 10/25/10 III State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Walter Clark Physician/ 9:00 PM October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Seasons Hospice and Palliative Care</u> <u>Randallstown</u> Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. 1 🔀 M 2 🗆 F Months Hours (Month, Day, Year) 03/01/1933 Director 215-30-1418 MD Usual Residence of Decedent mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.

oortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21236 4234 Necker Avenue . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give 10 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. TYES, Give Year or Dates. 1950-54 Specify: Completed 3 - Widowed 4 - Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repair 12 Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clark, Sr. Catherine Walter Η. Rolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4234 Necker Avenue, Baltimore, MD 21236 Dorothy C. Clark, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith 10/5/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. Ruck, Inc. Leonard andra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Cardiomypathy 5305 Harford Road, Baltimore Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an after death.

Director; After this certificate has page 2 s autopsy performed 1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home } 5 \) Residence 6 \(\text{Other (Specify)} \) 2 No Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskaj apakre M.D. 10/2/10 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 5MIM AV. 5. 203, Baltimore, MA. 21209-N.S. Rajapakse, M.D

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien 20 10 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:00P M Lewis carr 2010 October Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Birthpic Country) 7. Age (In vrs. last birthday **Funeral** 1 🗶 M 2 🗆 F Months Hours Min. 08-26-1928 **Director** 579–39–0053 82 Usual Residence of Decedent show or 28a-f shoven and an art 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1X Yes 2 No MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö "natural", or items 23a or edical Examiner must be Funeral 3710 BELLE AVENUE 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Yes Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRESIDENT LOCAL 1429 LONGSHOREMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARIE SMITH GEORGE CARR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 BELLE AVENUE, BALTO., MD 21215 RUBY CARR/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 X Removal from State WESTMINISTER GARDENS 10/10/2010 GREENSBORO, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to or as a consequence of thany leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached f g | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No} \) 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director. Be Other: 4 \(\text{Nursing Home } 5 \) Residence 6 \(\text{Other (Specify)} \) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural work?
1 Yes 2 No injury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number D0057465 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/3/10 Askajapamem.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209 N.S Rajapakse, MID 2835 Smith AV 5-203, 31. Date filed (Month, Day, Year) State parke Registrar OCT 0 5 2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 26, 2010 Month Physician/ 6:18 P September Elio Centenari Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Mays Chapel Ridge Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Month, Day, You March 4 1 X M 2 □ F Days Year) Country)
Italy Yrs Director 84 034-28-3133 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amorpriant: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 N No Maryland Baltimore Timonium 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? USA 12261 Roundwood Road 21093 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irma Petri Anthony Centenari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1924 Ruxton Rd., Balto., MD 21204 Peter Centenari/son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1🏋 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Cambridge, Massachusetts Cambridge City Cem. 10/4/10 4 Donation 5 Other (Specify) 21. Signature of Funeral Section Conseed
Michael J. Magle ^{22. Name and Address of Facility} Lemmon Funeral Home of Dulaney Valley Inc 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non-small cell Physician/ adenocarcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? atrial 24a. Was an arox y sma autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tyes 2 💢 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) D0018410

State Registrar 10755 Falls Road, suite 470, Lutherville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laura M. Mumford,

OCT 0 5 2010

31. Date filed (Month, Day, Year)

M.D.

September 27, 2010

21093

Janet Dymowski Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 2010 31087 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner Janet Lynn Dymowski 1559 hrs September 30, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A **Baltimore** 2708 Maryland Avenue If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. **Funeral** Foreign Maryland Months Davs Hours Director 216-54-2401 48 June 22,1962 2X F М Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland N/A 1 XYes 2 No Baltimore or items 23a or 28a-f shov must be notified at once. more, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant. If I fire m27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2708 Maryland Avenue 21218 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 XMarried 2 X No Yes Specify: White 1 Yes 2 X No specify: 3 Widowed 4 Divorced f Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper Marriott Hotel 12 N/A 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Leo John Dymowski Ann Julia Bolewicki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Sotaski (Sister) 4347 Hallfield Manor Drive Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 K Cremation 3 Removal from State crematory or other place Evans Funeral Chapel-Bel Forest Hill, Maryland 4 Donation 5 Other Specify: Oct. 3,2010 Air | Oct. 3,2010 |

22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 Si nature of Funeral Service Licensee 23a. Part I/E ter the dia ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardivoaculuar disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical X UNPENDED AMENDED, 27, per ME g909 11/5/10 TT attending physician or use as the burial P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) this certificate has been signed by the att I director, page 2 should be detached for 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No he Hospital or Attending Physician: Th in 24 hours after death. he Funeral Director: After this certifical pletely filled in by the funeral director, pa 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗓 Natural 1 Yes 2 No Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the I within 2 To the] 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 1, 2010 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 24a,25,26 per dr. 1998,10,05/2010dhb Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ IXON MARY 7:00 A M 2010 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore City 4302 White Avenue Baltimore, Maryland 8. Date of Birth (Month, Day, Year) September 29, 1919 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2/□ F Months Hours Min 90 212-10-6370 Director Marvland Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore City 1**X**□ Yes 2 □ No Baltimore, City Maryland Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4302 White Avenue 21206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-6036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed Specify. 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Palatine Brothers Mail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Felix Pruski Mary Janicki permit. Page 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4302 White Avenue Baltimore, Marvland 21206 Richard Dixon (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State September 23 1XXBurial 2 Cremation 3 Removal from State Gardens of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2010 Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore,Maryland 21236 water 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. LOID LEUKEMIA CUTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any scaling to him class cause. Enter Underlying Examine Due to (unas a nonsequence of) executed Cause (Disease or linjury signed by the attending physician and deedeched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy performed?

Yes 2 No death? Director: After this certificate and in by the funeral director, page 2 🗌 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 9,20,2010 D0070907

Registrar

State

nary

2

4940

EASTERN

AVE

BALTIMORE MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHANRHAG

OCT 0 5 2010

31. Date filed (Month, Day, Year)

ALIOA

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2010 Month Physician/ 7:45 p M Anna V. Desper Sept 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Dundalk Genesis Heritage Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🔯 F Months Days Hours 228-40-0955 77 september 23, 1933 Virginia **Director** Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 No Maryland 10e. Street and Number 10f, Zip Code ō 10g, Citizen of What Country? Examiner must be with 23a Funeral USA 21222 1701 Bethlehem Avenue items ? 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", White 3 Widowed 4 Divorced Completed event, the Medical Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Belle Rankin John Sipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1701 Bethlehem Avenue, Baltimore, Maryland 21222 Carl Desper Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State October Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4, 2010 gnal re of Fundral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death THEROSCLEROTIC CARDIOVASULAR DISEASE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): HYPERTENSION Examiner Seprendally list nonaltions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ARKINSON for use as the bunial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician STAGE Physician/Medical DEMENTIA death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morths?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death s been signed by the s should be detached 9 Unknown a Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne f Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 V atural 5 Pending 1 🗌 Yes 2 🗌 No Acciden
Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ♥ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Dundalk MD 21222

State Registrar 31. Date filed (Month, Day, Year) OCT 0 5 2010

DHMH 17 Rev 7/2009

2 Marke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A M 2010 6:00 October 0 Audrey Dolores Dudley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5543 Or<u>egon Ave</u>. Arbutus Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 4/21/26 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthday) Funeral Hours Min. 1 □ M 2 🔀 F Director 218-12-7094 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and I fleath and Mental Hygiene. and I file 23 so marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at oury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 🗌 Yes 2 🜠 No MD <u>Baltimore</u> Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5543 Oregon Ave. 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Kennedy Florence Earling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William W. Dudley / Husband 5543 Oregon Ave. Arbutus , Maryland 21227 Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 10/6/10 Baltimore, Maryland . Signature <u>of F</u>uneral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he not failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acch MI HRS Medical Due to (or as a consequence of) Examiner 896 Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed ins of clean 2019 and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) g Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 of autopsy performed? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Chierzi North 1/20 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 30, Physician/ 2010 3:02 AM Albert Rudolph D'Antonio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Elizabeth Nursing & Rehab N/A Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Nov 3, Yell 926 Mary Land 215-22-4728 83 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director iral", or items 23a or 28a-f s Examiner must be notified 1 Tes 2 No Baltimore Catonsville Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 USA 1913 Clifden Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1X Yes 2 No 1945 'natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. If Yes, Give Year or Dates 1946 Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Ouality Control Inspector Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve 2 Emanuele D'Antonio Angela Franceschetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1913 Clifden Road Catonsville, Maryland 21228 Charlene Burns, Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date remetery, are matery or other place)
Memorial Gardens 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Maryland 10/04/10 21. Signature of Funeral Service Licensee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? Year Month Dav 2 No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 7/2009

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items1 per doc 10b,16b,19a per fh g908 10-12-10 vt

State of Maryland / Department of Health and Mental Hygiene Reg. No.20 State Registrar Certificate of Death Mark Whitlock De Angeli 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Sept. Physician/ 30, 2010 9:29 A De Angeli Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) United (Month, Day, Year) Months 1 X M 2 □ F **Director** 54 Yrs. 158-54-5366 12,1956 Kingdom April Usual Residence of Decedent 10b. County St. Croix 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Director Unk_{1• Yes 2 No} VI Croux Frederiksted 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 00841 3 A Butler Bay Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Yes 2XXNo Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Property Elementary/Seconday (0-12) College (1-4 or 5+) Developement Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Μ. Whitlock Joan De Angeli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane De Angeli/ Sister 7006 Oak Forest Lane, Bethesda, MD 20817-2124 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory | 10/1/2010 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 21. Signature of Funeral Service Licenser MO0382 Stephen Lot Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPS18 Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dewithing 42 hours after death.

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🕍 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 William 1 ☐ Yes 2 PNo 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. A Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0005 on, uno

Registrar

State

0929 am

9/30/10

7001

Deangeli, Mark

10110 MOLECULAR DR #20L

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BAG MD

IRUGNA (SA)
31. Date filed (Month, Day, Year)

OCT 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical (if not institution, give street and number) **Examiner** tonsville more 8. Date of Birth If Unde or Foreign 9. Birthplace **Funeral** 1 □ M 2 🖬 F 80 **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other pla 4 Donation 5 Other (Specify) Jarri50n tores of Funeral Service Licenses 21. Signature reene 23a. Part 1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ EVELOU Medical resulting in death) Due to (or as a sequence of) HROWS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit the Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗓 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 5 Pending Natural work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director: A Oct 4,2010 541 KOYEL WID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(FITHA RAJA MI) 4367 Hollins Ferry Beltoning, MD-21227 Rd. 32. Registrar's Signature State 05 Registrar ✓ DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ 07:20 PM 03, 2010 David Clark Fuellhart Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hartor Grace tizens Jursing 1)e tarre If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Oct. 16, 1938 Pennsylvania Director 207-28-3186 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗓 No Harford Bel Air Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 21014 52 E. Broadway Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' X Yes 2 N1963-1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 🗆 Widowed 4 🔀 Divorced 1967 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Radio 4 Businessman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Μ. Marsh William C. Fuellhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 145 W. Hickory Avenue, Bel Air, Maryland 21014 Mark Carroll, Gaurdian 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/4/2010 Baltimore, Maryland 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death eludration Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a conseque (ce 1f): Examiner 612KS Mu Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) William D32609 10-04, 10 MD 30. Name and address of person who completed cause of death (Item 23a) Type, Print) evolution St Havre De Grace MD 21078 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

DCT 0 5 2010

10-07582	
Tammy Fisher	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

ammy Fisher	State of Maryland / Department of Health and 1-For State Certificate of Death	Reg. No. 2010 31095
Physician/		2. Date of Death Month Day Year
Medical Examine	Tammy Ann Fisher 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lu	October 2, 2010
	2036 Flintshire Avenue #101 Rosedale	Baltimore County
Funeral Director	5. Social Security Number 219–92–4700 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) 48 Yrs. 1 Days	Hours Min. August 21, 1962 Shirthplace (State or Foreign Country) Maryland
, any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Varyland 28a-f show any d at once. Pector	Maryland Baltimore Rosedale	1 Yes 2 X No
the Maryland to 28a-f sh tified at once Director	10e. Street and Number 2036 Flintshire Road Apt. 101	10g. Citizen of What Country? United States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No	
5-0036 ed within 72 hours a tygiene. other than "naturs the Medical Exami	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation during most of working life. I 17affic Contr.	DO NOT use retired)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Re Commit		B.Mother's Name (First, Middle, Maiden Surname) Patricia L. Unsoeld
212 hould b nd Men is marl	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	and Number or Rural Route Number, City or Town, State, Zip Code)
and 2 si lealth ar tem 27 traums	20a. Method of Disposition 20b. Place of Disposition (Name of cem-	t Apt. D Parkville, Maryland 21234 etery, Date 20c. Location - City or Town, State
more Pages 1 ent of H nt: If i	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	el Oct. 7,2010 Forest Hill, Maryland
Baltil permit. Departm Importa	Signature of Funeral Service Licensee 22. Name and Address Evans Funeral Service Licensee 23. Name and Address Evans Funeral Sevents Funeral	l Chapel & Chemation Services-Parkville Road Parkville, Marvland 21234
Physician /Medical	23a. Part I Errer the direase, or complications that caused the death. Do not enter the mode of dying, stallure List only one cause on each line.	Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a Cocaine and Narcotic Intox Due to (or as a consequence of):	Teation
	Sequentially list conditions, b	
	cause. Enter Underlying Cause [Disease or injury that initiated cause or cause or cause or injury that initiated cause or cause	
uted nd ransit	events resulting in death) Last Due to (or as a consequence or). d	
50, te be executed tysician and e burial - transit	☐ AMENDED 23a,27,28a-f per me g	
b. Box 68760, the death certificate be executed to the attending physician and ched for use as the burial - transition of the executed for use as the burial - transition of the executed for the second of the executed for the ex	E I LE FEMALE: I Z3C IT Ves. QUICOME OF DIEGLIATICY	Ectopic pregnancy Month Day Year
ਦ > 5 l o	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	ven in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O.		1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached	26 Place	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Recision: The certificate ector, page	25. Was case referred to medical	of Death (Check only one) Other4 Nursing Home 5 Residence 6 Other: Scene
Physic Physic rer this	27 Manner of Death 128a Date of Injury 28b. Time of Injury 28c. Injury	Other Nursing Home 5 Residence 6 Other: Scene v at Work? 28d. Describe how injury occurred
on of tending Pl sath. or: After the funera	The Natural State of the Natur	es 2 X No unknown
Division of Vital Rec pital or Attending Physician: The ours after death. Filled in by the funeral director, page	3 Suicide 6 🗷 Could not be 28e. Place of Injury - At home, farm, street, factory, office but	or Town, State)
Division To the Hospital or Attendit within 24 hours after death. completely filled in by the fi		te and place, and due to the cause(s) and manner as stated.
of the F on plets of the F	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, and manner stated.	death occurred at the time, date and place, and due to the cause(s)
	29b. Signature and title of certifier 29c. License O.C.N	
	30. Name and address of person who completed cause of death (Item 23a)	
7	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201
Sta		

Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	arylan	d / Depa	artment of H	lealth a	ınd M	ental Hyg	giene				
			State Registrar			Cer	tificate of <i>E</i>	Death			Reg. No.	2010	3	1096	
	Physicia		Decedent's Name (First, Middle, Aubrey	, Last) Brian			Fisher 2. Date of D. Month Octob				Dav	, 201		e of Death	
	Medic Examin			a. Facility Name (if not institution, give street and number)					f Death	oc cobe		County of Deat		2 11	
			Gilchrist Hos	pice				wnson			В	altim	ore		
	Funeral Director		5. Social Security Number 217–56–3702	6. Sex 7. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birtl (Month, Day April 10	Year) 1952	9. Bir Co Mar	thplace (Sta untry) 'yland	te or Foreign	
			Usual Residence of Decedent							PALLE 10	1332	1 1 1000			
	ryland I-f sho Ied at	Director	10a. State 10b. County	imore	10c. City	, Town or Loc	ation SSEX							e City Limits	
	ne Ma or 28a notif	Dire	Maryland Balt:	IMOLE	_	152	10f. Zip Code		_		10a Citiz	1 ☐ Yes 2 ☐XNo			
	with the s 23a c	Funeral	2010 Middleboro	ough Road			21221					JSA	,		
	death items ner m		11. Marital Status	12. Was Decedent E Armed Forces?		i. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origi n, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)	1	4. Race - Ame Black, Whit		1,	
Maryland 21215-0036	le 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No	1	☐ Yes 2 🔀 No	Specify:			s		nite		
2-0	2 hour "natu	plete		nt's Education st grade completed)			ent's Usual Occupa		of working	g	16b. Kin	nd of Business	Industry		
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altimore,	Page 1 ment of ant: If ii ury or c		1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (S		CE	emetery, cren	natory or other place Crematory		Octo 2, 2			imore,			
Balti	permit, Page Department Important: I any injury or	0	21. Signature of FunerahService L		el.		Name and Address nnelly F 110 Solle	1							
			23a. Part 1. Enter the disease, or shock, or heart failure. List d	complications that caused	the death							LIN, LIV.	Approxi		
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	Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):	100		_\	0 (
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	consequ	ence of):	ulest	M	CW	Ow	7				
	uted	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	с											
	death certificate be executed ne attending physician and ed for use as the burial-transit		resulting in death) Last	Due to (or as a	consequ	ence of):									
760	cate b physic	edical		d											
687	certific	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnanc	.,			2	3d. Date of de	livery		
Box	requires that the death certifica been signed by the attending p should be detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown			Other (specify)	,				Month	Day	Year	
P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach	by P	Part II. Other significant condition	ns contributing to death b	ut not resu	ulting in the u	nderlying cause giv	en in Part I.	,			e contribute to			
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Division of Vital Records,	ne law n e has b age 2 s	Completed	HEBENT	y C.						24a. Was a autop perfor	sv	prior to	completion	of cause of	
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₹	Physic this ce al dire	은	1 ☐ Yes 2 No 27. Manner of Death			ER/Outpatien		4 ∐ Nur				Other (Spec	ify) HO	spice_	
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/isio	r Atter er dea rector by the	Certificate:	3 Suicide 6 Could a Homicide determ	not be	ry - At hor	me, farm, stre	et, factory, office		2	8f. Location (S City or Tow		Number or Ru	ral Route N	umber,	
2	pital or ours aft eral Dii		00-0-15									l mannar as at	ata d	<u> </u>	
	n 24 hc n 24 hc ne Fune	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of ex Nurse Practioner: To the	kamination	and/or invest	igation, în my opînio	n, death occ	curred at t	he time, date a	nd place, a	and due to the	cause(s) and	manner stated.	
	To the vithii To the comp		29b. Signature and title of certifier		_		29c. License		0 =		29d. Date	signed (Mont	n, Day, Year)	
		4	1	$-\omega$	()			712	18		10	1110			
			30. Name and address of person	who completed cause of de	eath (Item	23a) (Type, P	(o) CA	to	410	- Ro	Fa.	1020	MA	NOLIE	
	Stat		31. Date 0 CT 0 1,5 2010	32. Registra	r Signat	Jack	100	11	110	J (1) G	I LE, M	~~~~		W. WO	
	Registra	ar	331 0 0 2010		1										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER Year JOHN Physician/ FERGUSO 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE ANNE ARUNDEL BALTIMORE WASHINGTON MEDICAL ENTED Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Days 1 😿 M 2 🗆 F Months 09/21/197 39 Director 042-62-7664 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. notified at Director 1 ☐ Yes 2 🏻 No 28a-f MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21234 U.S.A. 2315 Wilker Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 M Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Information Technology Computer Programmer To Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bullock Mary Ferguson John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John J. Ferguson, Father 5 Farmstead Lane, West Simsbury, CT 06092 27 Important: If item 2: any injury or other tonce. Date UNK 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State Simsbury, CT 4 Donation 5 Other (Specify) Simsbury Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J.Ruck, Inc. Suprovell Baltimore, MD 21214 5305 Harford Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate R Interval Between Onset and Death Immediate Cause (Final Physician/ DROWNING disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SORDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month sate has been signed by the atte page 2 should be detached for Year Pregnant at time of death Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 🗌 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 <u>N</u>atural 5 Pending UNKM Seizure 2 No 151 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office pullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Aguatic runde Medical Certifying Physician: To the best of my knowledge, deal occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License numbe MD D00 63564 HOSPITA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Medical Center Patel, MD MD2106,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FERGUSON, JOHN

backs

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death	F	Reg. No.	0 01000
	1. Decedent's Name (First, Middle, Last)	2. Dete of Dee		3. Time of Death
Physician /Medical	MARJORIE F. FLEMING	OCTOBE	R 2, 20	10 4:13 AM
Examiner	4a Pecility Neithe (II not institution, give street end number)		40. County o	Doom
	426 N. PATTERSON PARK AVENUE BALTIM 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 H	S. 8. Date of Birt	th ,	Birthplace (State or Foreign Country)
Funeral Director	214-20-9200 1 M 2 F 90 Yrs. Months Days Hours Mi	12-25	y, Year) -1919	MD MD
fand	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
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ath with the Merylan 23e or 28e-f show Last be notified at ral Director	10e. Street end Number 10f. Zip Code		10g. Citizen of W	het Country?
Sa Cla			USA	
r items 234 riner must funeral	11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No		- American Indian, , White, etc.
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should be nd Mentel marked o imatic eve	EUGENE ADAMS MAR	Y TYREE		
2 should lead Menis market	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rurel Route Numbe	er, City or Town, S	Stete, Zip Code)
	MYRA MONDIE 5322 MIDWOOD AVE.	BALTIMOR		21212
of Heali of Heali item 2 r other	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - 0	City or Town, State
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보 본 원은 ,	21. Signature of Funeral Service Licensee 22. Name and Address of Facility			& SONS F.H., IN
Deperiment of the control of the con	James G. Morton 1701-31 LAURENS S	ST. BALT	IMORE, M	D 21217
	23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician	a solution + Cl			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) a. Conjective Neart far luv	e		
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The law require sets has been single has been single 2 should Completed	diverticular disease	perfo	ormed?	available prior to completion of cause
hasb pe2s mp1		2000		of death?
ne is sete ha page		10	Yas Z.Mo	1 ☐ Yes 2 ☐ No
ysician: The sis certificete director, pag	25. Was case referred to medical 26. Place of I	Death (Check only		-
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fter the neral ner	27. Manper of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe	how injury occurr	90
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the Hospit hin 24 hour the Funera mpletely fill		consec at the time,		(Month, Day, Yeer)
To the Hospital or Attending Phywithin 24 hours eiter death within 24 hours eiter death completely filled in by the funeral Medical Certification: 1	29a. Certifler (Check only one) 2 Medical Examiner: On the best of my knowledge, deeth occurred at the time, date and pix one) 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death of and manner stated. 29b. Signeture and title of certifier 29c. License number	Scalled at the time,		
To the Hosp within 24 ho To the Fune completely f	29b. Signeture and title of certifier 29c. License number D3510	2		
To the Hospital within 24 hours To the Funeral completely filled Medical C	29b. Signeture and title of certifier 29c. License number 29c. License number D 35 10 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)	2		
To the Host within 24 ho To the Fune completely f	29b. Signeture and title of certifier 29c. License number D3510	Z Balt		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09 Month 28 2010 Frazier Kevin Dwight 11:46aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 109 South Catherine Street Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.1 | 0.4 | 6.4 | 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ★ M 2 🗆 F Director 213-84-7677 MD Usual Residence of Decedent show at 10a, State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 X Yes 2 🗆 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 U.S.A. 109 South Catherine Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian "natural", or iten Armed Forces Black, White, etc. Never Married 2 Married þ Yes 2 No 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed er than "natura the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Univeristy Of MD Elementary/Seconday (0-12) College (1-4 or 5+) filed within Hygiene. Hospital marked other t Housekeeper 2th grade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed trent of Health and Mental H tant: If item 27 is marked ot jury or other traumatic ever ပ Elizabeth Washington Frederick Frazier Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 109 South Catherine Street, Baltimore, Tinika Frazier-Daughter Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 😾 Burial 2 🗔 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 10/4/2010 Baltimore, Md Zion . Signature of Funeral Service March FTH West lar 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Physician/ disease or condition 27/10 Due to (or as a consequence of): Medical resulting in death) Examiner several ballontops 1 eur Sequentially list conditions, Examiner cause (Disease or iinjury Drie to for selections are Several signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed uncontrolled yeur that initiated events resulting in death) Last Due to (or as a consequence of): Several by Physician/Medical Division of Vital Records, P.O. Box 68760 Yeurs IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed hyperlipidemia WIO BICA 1 Yes 2 No 3 Probably 4 Donknown peen s 24b. Were autopsy findings available prior to completion of cause of death? page 2 s cropie ulcars Duncreatitis To the Hospital or Accommending 24 hours after death.

To the Funeral Director. After this certificate I performed? neuroputa Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 46 Other: |은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ☐ Natural work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo D0066473 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fripp Edmondson Ave Bultimore 21229 MD Natelaine

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 5 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 2. Date of Death 3. Time of Death cedent's Name (First, Middle, Last) 10:45 AM Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore City The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 - 22 - 65 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** BO 44 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County show must be notified at 1 ☐ Yes 2X No Director Pembroke BO NA 28a-f 10g. Citizen of What Country 10f. Zip-Code 10e. Street and Number ö Bermudian 23a HM13 13 Crane Lane Funeral death 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after Examiner 1 Yes 2 If Yes, Give Year or Dates: XXNever Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗓 No Specify Specify:American ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Novartis al Hygiene. I **other than** " Elementary/Secondary (0-12) 2th Grade College (1-4 or 5+) Pharmeceutical 12th ΝĀ Office Manager Ith and Mental Hygi 27 Is marked other r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E11a Greaves Robinson Reginald ρ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6 Fourth Avenue Shelton Road Pembroke, BO Robin Francis-Sister Health a other nt of Head : If item or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State John's Cem. 10-15-10 Pembroke, BO 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses N. Gilmor Street Baltimore, MD 21217 638 23a. Part 1. Enter the disease, or complications in a caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cap each line Immediate Cause (Final DOXIG **Physician** disease or condition resulting in death) /Medical (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cauce (Dicease of the cauce) Examine or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ☐ Pregnant at time of death Month Day Year for 5 Other (specify) 2 🗌 No d by the a 9 Unknown 9 Nunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de δ 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 X No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Ainpatient Other: 4 \square Nursing Home 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ this funeral 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: (Month, Day Year) Injury Natural 2 Accident 5 Pending investigation 1 TYes 2 □ No 3 🗌 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 M)

Registrar

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 26per PHYS, G908, 10/5/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month Ferrell September 2010 430 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18413 Emory St. Gaithersburg Montgomery Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year I If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday, 8. Date of Birth Funeral 1 ፟፟፟፟M 2 □ F July 17, 1950 Yrs Director 60 215-54-5543 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ukn 1 □ Yes 2 □ No Director ral", or items 23a or 28a-f s Examiner must be notified VA Lee Jonesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1909 Red Fletcher Rd. 24263 United States I and 2 should be filed within 72 hours after death f Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 M Married 1 X Yes 2 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White rr Yes, Give Year or Dates.1969-72 3 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tree Surgeon Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ferrel1 Sherry Bernice Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy A. Ferrell / Wife 1909 Red Fletcher Rd., Jonesville, VA 24263 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1; 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 10/4/2010 Beltsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ²², Name and Address of Eacility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 M@382 23a. Part 1. 5 for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition hroat Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir been signed by the attending physician and should be detached for use as the bunal-transit Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 autopsy 2 XNo 1 Yes **Division of Vital** Be (25. Was case referred to medical 26. Place of Death (Check only one) Sister's examiner? Hospital: Other: ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37142 0105-1-01 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Rockville G. Gle Drive MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death Month Year Physician/ CTUBOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTIMORE TIMOR 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F Days Months Hours 88 NOV. 03, 1921 Philadelphia, PA 169-16-7520 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director **Parkville** 1 Yes 2 No 28a-f **Baltimore County** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō United States Funeral 21234 items 23a 10 Topwood Court permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1,4 or 5+) Pollock Johnny's Food Service Owner Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Ma Matilda Feldman Middle, Maiden Sumame Frederick Geirsch ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Phoenix, MD. 21131 12833 Stone Eagle Road Mrs. Gloria A. Baldauf (Daughter) 20c. Location - City or Town, State (Harford County) 20a. Method of Disposition 20b. Place of Disposition (Name of Evers fure all Charel and Cremation Services, Inc. 1 Burial 2 Cremation 3 Removal from State Saturday 4 ☐ Donation 5 ☐ Other (Specify) Oct. 02, 2010 Forest Hill, Maryland Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Page and Adverses of Facilities Funeral & Chemetican Center, P.A. 2325 York Road Timonium, Maryland 21093-2251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEART ONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MYOCARDIA Caquandany list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin OLONARY Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ASTROLNTESTINAL Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 5 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Acciden injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI ress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Rea State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #1 Per PHY &19a&b Per INF G918 8/09/2011 JH State of Maryland / Department of Health and Mental Hygiene amend 8 per a.b. g911 1/7/20 dertificate of Death 1. Decedent's Name (First, Middle, Last)

Baby Boy Sambath Kumar

Boy Gopal-Krishnan Twin 2. Date of Death 3. Time of Death Month Physician/ 49 AM 2010 Medical 4a. Facility Name (if not institution, give street and number 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Rose dale
If Under 1 Year If Under 24 Hrs. Square timore HOS pita ranklin 8. Date of Birt 9/20/10 9. Birthplace (State or Foreign **Funeral** infant 1 🕅 M 2 🗆 F Months Hours Min. Maryland Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Harford 1 ☐ Yes 2 √ No Abingdon 10e. Spotand Manberings Court 10f. Zip Code 10g. Citizen of What Country? 21009 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 X Never Married 2 Married 72 hours after 5-0036 1 ☐ Yes 2 🔯 No Specify: Specify. Indian 3 Divorced Year or Dates. event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant and Mental Hygie is marked other Be RISh ha 17. Father's Name (First, Middle, Last) Sambath Kumar Palaniswamy SAmbath P. Gopal Krishnan 18. Mother's Name (First, Middle, Maiden Surname) ٥ I and 2 should be fill I Health and Mental Item 27 is marked Lavania Gopal-Krishnan other traumatic 19aTingman'a Name GopaThio Kristinan Franklin Square Hospital 191901 in Gidle to Engis no (Member Albring to thug MI) Cit 1009 State, Zip Code) 9000 Franklin Square Drive Rosedale, MD Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date É cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) in state State Anatomy Board 655 W. Baltimore Street MD imore Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Extrem Virmatur Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner (m) Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit norma and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown detached ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 X Inpatient 2 - ER/Outpatient 3 -4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicing To the best of ny knowledge order occurred at the time, date and claim to the cause(s) and manner as stated. (Check Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) kaplan 9000 Franklin Square Drive Balt, more, MD 31. Date filed (100 Day, 5 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SYLVESTER GRAY 200 10:38A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOSEPH RITCHIE BAUTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Hours Min. 262-62-4193 Months Director 55 Usual Residence of Decedent 23a or 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD WASHINGTON HAGERSTOWN 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 818 POTOMAC 21740 SOUTH USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 ☐ Married Completed by 1 Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) DETAILER A UTO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FISHER AWRENCE WAUTOR MARY RUTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
87 BLUE RIDGE CT FROORICK MD 21703 VORETTA DOTSON SIS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FROOKRILLE MO PAIRVIEW COM, SUDT 30, 20(0 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liversee 22. Name and Address of Facility GARY L, ROLLINS PUN KEMIG Collin Duy X. 110 WEST SOUTH ST FRED WILL MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rena end-stage disease or condition **Medical** resulting in death) Due to (or as a cons-quence of): Examiner 515 Sequentially list conditions, in a cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or an a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death ned by the atter e detached for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ension División of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Viab cate has I autopsy performed After this certificate 2 🗆 No Brue 1 Tes Yes 25. Was case referred to medical the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) Nursing Home 5 \(\sum_{\text{Residence}}\) Residence Hospital: 1 🗌 Yes 2 🗖 🖔 vother specifice 10115e ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Richey 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 eph 21224 31. Date filed (Month, Day, Year, State Registrar

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3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 25 2010 Mod Olivia Gray 2:07 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 213-58-7534 1 🗆 M 2 🗷 F Months Days Hours Min. (Month, Day FEDERICK 67 Director Usual Residence of Deceden show or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Director FREDERICK 1 Yes 2 No MD FREDERICK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r Funeral APT 408 USA TANLY AVE 21702 1421 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🛮 No Specify: Specify: BLACK "natural", 3

✓ Widowed 4

☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mandatone. Elementary/Seconday (0-12) College (1-4 or 5+) Home 10 TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ LYCES ANDREW SIMMS MABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAU SILUGE SPING 20904 RD MD. JACKSON 1323 SMITHVILLE TERRY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, FREDORICK FAIRVION COM. QT. 2,2010 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility GARY L. RULLINS FUN. HOME Rolle rang X. 21701 FLEDERICA 51 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ATHENO orlown Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: nse i 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy page performed Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Tyes ျ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending injury after death. 1 Yes 2 No Investigation 6 Could not be 3 Suicide To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701.

DHMH 17 Rev 7/2009

State Registrar SIBTE A KAZMI.

31. Date filed (Month, Day, Year

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Registrar's Signature

TOU HOUSE AUF.

TREDERICK

State of Maryland / Department of Health and Mental Hygiene [] for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 9:30 **P.** M Roslyn Maria Gillis Medical September 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8819 Falcon Ridge Drive Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Min 1 □ M 2 🕅 F Months Yrs **Director** 218-58-3890 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MDBaltimore Randallstown 1 Tes 2 XNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 8819 Falcon Ridge Drive 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: African-American 'natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Program Analyst Housing Authority Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once. Russell Creighton Stella Gaskins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick S. Gillis/ Husband 8819 Falcon Ridge Drive, Randallstown, MD 21133 20a. Method of Disposition Entantment 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) 10-7-2010 Druid Ridge Cemetery Pikesville, MD e of Funeral Service Licen 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Pary . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, erock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician/ 1-TASTATIL BreasT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 perform 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death, Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10018320 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RS 1075 Joh M TALLS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 30, Physician/ September Edna Mae Gruber 2010 11:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 1502 Old Philadelphia Road Aberdeen Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** May 30, 1935 Days Hours 1 □ M 2 🔀 F Director Pennsylvania 164-28-0560 75 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1502 Old Philadelphia Road 21001 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant. If item 27 is marked other than 'ary or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Leroy Signor Mary Verna Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas E. Gruber / Son 626 South Stepney Rd., Aberdeen, MD 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gdns: 10-5-10 Aberdeen, Maryland Name and Address of Facility
McComas Funeral Home, P.A. 21. Signatura of Funeral Service License 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebroviscular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner cardiomyopa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Dav Year Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by vascular 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore Parte1 701 Nchanes 32. Registrar's State Registrar

10-07562 Donald Gregory Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onald Gregory		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2010 31108							
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) DONALD L. GREGORY				2. Date of Dea Month October 2	ath Day Year	3. Time of Death 0047 hrs	
		4a. Facility Name (if not institution, give street and number) Harbor Hospital	4	b. City, Town, or I Baltimore	ocation of De	eath	4c. County of E		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 12 M 2 F 53	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	MAY 2	, 1957	Birthplace (State or preign CountryMICHIGAN	
daryland 28a-f show any 1 at once.	tor		10c. City, Town or Location MONTROSE TOWNSHIP				10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No	
ith the Maryland 23a or 28a-f sho notified at once,	I Director	11135 WEST DODGE RD		10f. Zip Code 48457			USA	ouriny?	
r death wi	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced or Dates:	lf Y∈	es, specify Cuban, Yes 2 X No	Mexican, Pu		White, e	WHITE	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	during mo	's Usual Occupationst of working life.	DO NOT use	retired)	16b. Kind of Busine AUTOMOTI	,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) DONALD F. GREGORY	Lan mar		MARY :	ame (First, Middle,			
MD 2 Id 2 shoul Uth and M m 27 is m sumatic	ပ္	19a. Informant's Name/Relationship (Type, Print) NANCY GREGORY-WIFE	1113	5 WEST DO	ODGE R	D MONTE	mber, City or Town, S ROSE, MI 4	8457	
Baltimore, permit. Pages 1 an Department of Hea Important: If ites		1 X Burial 2 Cremation 3 Removal from State	crematory or othe RESTWOOD	CEMETER	Y 1	Date 0/7/10	20c. Location - Cit	ANC, MI	
Balt permit. Departi Import injury		21. Signature of Funeral Service Licensee	PPEL FUNER E, MD 2120	AL HOME, INC					
Physician /Medical Examiner		23a. Part I. Enter the disease of comclications that caused the death failure. List only one cause neach line. Immediate Cause (Final disease a. Atherosclerotic Cardiov			uch as cardia	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death	
		or condition resulting in death) Due to (or as a consequence of Sequentially list conditions,							
cd Sit	Examiner	if any, leading to immediate cause Enfort Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence o							
60, e be executed ysician and burial - transit	edical	d AMENDED		<u> </u>					
ox 6876 ath certificat attending ph or use as the	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of degree 1 Unknown	2 Feta	al death 3 er (Specify)	Ectopic pre	gnancy	23d. Date of deli Month	very Day Year	
ires that the signed by the detached	d by Phys	Part II. Other significant conditions contributing to death but not r Diabetes Mellitus	esulting in the un	ederlying cause giv	ven in Part I.			e to the cause of death? Probably 4 🗹 Unknown	
tal Records, cian: The law require certificate has been si ector, page 2 should b	Completed							autopsy findings available to completion of cause of 1? Yes 2 No	
Vital hysician: this certif	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	ER/Outpatient		of Death (Che		Residence 6 0	ther;	
Division of Vital Isl or Attending Physician: Is after death. To all Director: After this certicled in by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28b. Time of Inj		at Work?	28d. Describe	how injury occurred		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At h	ome, farm, street	, factory, office bui	ilding, etc.	28f. Location (S or Town, S		Rural Route Number, City	
To the Hos within 24 h To the Fur completely	edical	29a. Certifier 1 Certifying Physiclan: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a and manner stated.							
	Me	29b. Signature and title of certifier		29c. License O.C.M			29d. Date signed (October 2, 20		
	ľ	30. Name and address of person who completed cause of death (Item Ana Rubio MD. Assistant Medical Examiner		reet, Baltimor	e, MD 212	01			
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	referred						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 30, Physician/ 2010 Calvin Goon Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** n/a Baltimore 321 S. Augusta Ave 1 Year If Under 24 Hrs.
Days Hours Min. 5. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 8/1/27 Year) 1 X M 2 D F Months Maryland 83 Director 219-22-0760 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 X Yes 2 No MD n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 321 S. Augusta Ave. 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give Year or Dates. 1950-56 Black, White, etc. ş ö 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Chinese Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) City of Baltimore Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental ant: If item 27 is marked or ပ George Goon Lee Toy Shim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21229 321 S. Augusta Ave. Mrs. El<u>len J. Goon</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1
Department of I
Important: If it
any injury or o 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/6/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home Signature of Funeral Service Licenses 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. romplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
On Day Immediate Cause (Final disease or condition resulting in death) Physician/ (81 JU Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate course. Entire I Industrying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 4 Hospital or Attending Physician: The law requires that the death certificate be 6 24 hours after death.

5 Funeral Director: After this certificate has been sinned by the attending a control of the state of th Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the state of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi only one) 29b. Signature and title of cer

State Registrar 31. Date filed (Month, Day, Year,

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on who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 29. Physician/ Robert Golding 2010 3:25 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12814 Broadmore Rd. Silver Spring Montgomery 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Nov. 5, 1931 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 - F Months Hours 78 Director 474-30-5216 Yrs Nov. New York Usual Residence of Decedent , or items 23a or 28a-f show miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12814 Broadmore Rd. 20904 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Injury or other traumatic event, the Medical Examiner Armed Forces' Armed Folces:

1 X Yes 2 No Korean
If Yes, Give
Vear or Dates. Conflict Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: 3 🗌 Widowed 4 🗆 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Economist United Nations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown and 2 should be Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healt Important: If item 2: any injury or other t Evelyn Golding / Wife 12814 Broadmore Rd., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory: 10/1/2010 Beltsville, MD Name and Address of Facility
app Funeral and Cremation Services
33 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due o (o Due to (or as a consequence of): resulting in death) Last burialending physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 N 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ည 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Suicide 1 \square Yes 2 🗌 No Investigation after deat 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fi Certifying Nurse Practioner: To the best of my knowledge ath oncurred at the time, date and plane, and due to 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MD 20852 6000 EXECUTIVE BLVD EE D HING - CHUNG

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ JEREMIAH S. GAITHER 3:16Ам 9 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 9. Birthplace (State or Foreign 5. Social Security Number 5 7 8 - 28 - 1 4 4 5 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, 1 🔀 M 2 🗆 F Days WASHIM GTON, Director /1925 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD PRINCE GEORGE' HYATTSVILLE 1X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6500 RIGGS RD 20783 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by "natural", or 1 Never Married 2 Married 1 XYes If Yes, Give 2 🗆 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: BLACK Specify: 3 Widowed 4 Divorced Year or Date 1. 9 5 2 -54 is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) PAINTER PRIVATE 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ GRANVILLE GAITHER /ESTA MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i SARGENT RD NE #207 WASHINGTON, DC 20017 MARION FITZHUGH/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State QUANTICO, VIRGINIA 4 Donation 5 Other (Specify OUANTICO CEMETERY 9/21/10 Funeral Service Lice 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND NE WASH. AVE., 20002 23a. Part 1. Enter the disease, or complications that caused the death. Durant shows, or heart failure. List only one cause on each line. t enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 Yes 2 No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 1 24 hours after death. Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: 1 ☐ Yes 2 🔀 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 X Natural 5 Pendina after death. Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar title of certifie D46520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 37 MYEJIAKA HAMOVERPARKMAY GREENBELT IDR 31. Date filed (Month, Day, Year) State OCT 0 5 2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ictory Day 21 010 **Physician** WILLIAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death Examiner BALTIMORE BALTIMORE SINAI HOSPITAL GEBALTIMORE 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex. 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) N/A 219-28-7190 238933 Director Usual Residence of Decedent City, Town or Location Baltimore 10d. Inside City Limits 10b. County 10a State 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinating mant by rutilied m N/A 1 XYes 2 □ No MD Director 10f. Zip Code 21207 10g. Citizen of What Country? 10e. Street and Number death with USA 3804 N. Roger Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1953 If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Amer. 1 □Yes 2X No Specify: <u>ک</u> 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event and once." Trucking Elementary/Secondary (0-12) College (1-4or 5+) Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Velma Johnson William J. Gray, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3804 N. Roger Ave., Balt., MD 21207 Pamela Stevenson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forestv 10/14/10 20a. Method of Disposition Owings Mills, Md 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Fuher J Semice Lice 5126 Belair Rd, Balt., MD 21206-5105 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIAL Immediate Cause (Final 20min Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner END STAGE RENAL FAILURG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) been signed by the should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sh autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 🗷 No spital or Attending Physician: The hours after death.
neral Director: After this certificate y filled in by the funeral director, par 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 🔁 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #400 Pikes Ville, MD21208 1838 GREENE TREE 1. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month *0200* AM a Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 8. Date of Birth (Month, Day Jan. 24 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 1923 Pennsylvania Director 189-12-8517 87 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Direct Talbot 1 Yes 2X No Maryland Cordove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral U.S.A. 31529 Miller Road 21625 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Mary Katherine Murphy John W. Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31529 Miller Road, Cordova, Maryland21625 Maryanne Stinson 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State New Brighton, PA. 10 - 2 - 10St.JosephCemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A Michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one or page on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consecuence on n any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 7 1 🗶 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending Natural 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sign and titl 29d. Date signed (Month, Day, Year) 29c. License number npleted cause of death (Item 23a) (Type, Print) 3900 State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Z Z Year 1925 PM Norma Jean Helm 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN BelTimore Sa Rosedale 012 HOSPITEL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min. 01/15/ Country) Director 70 216-36-0497 NC 1940 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No Middl<u>e River</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Mersey Court, Apt. 21220 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. ρ 1 Never Married 2 Married ☐ Yes 2 📉 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earnest Littleiohn Alma Lee Pike 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Schleicher Mersey Ct., Apt K, Baltimore, Md 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🗶 Removal from State っ 4 ☐ Donation ₄5 ☐ Other (Specify) Science 9/28/10 Care Aurora, CO Signature of Full of Service Licensee 22. Name and Address of Facility 7221 Grayburn Drive Glen Burnie, MD 21061 Harman F.S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Fatal arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ATherosclerotic cardiovasuar Diseas e Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: Exami mellitus the Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical d. HyperTension Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypercholesterolemia has been signed a should be 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha lirector, page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ္ within 24 hours after death.

To the Funeral Director: After this (completed filled in by the funeral dir 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b, Signature and title of certifie D0061662 23/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print))onaThan FAANKLIN SQUERE DR Balto ind 21237 HANSEN 9000 32. Registrar's Sanatur 31. Date filed (Month, Day, State 0 5 2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bertha Louise Heckler 2010 October 4:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Multimedical Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth
(Month, Day, Year)
Sept. 28, 1921 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 TYP 166-18-8924 Pennsylvani a Yrs Director 89 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 28a-f Baltimore Perry Hall 1 🗆 Yes 2 🕺 No MD 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8934 Kilkenny Circle 21236 USA items death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 → Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med within 7 Elementary/Seconday (0-12) College (1-4 or 5+) At Home the Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ permit. Page 1 and 2 should be 1 Department of Health and Ments Charles Busch Katherine Ostertag 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health ar Important: If item 27 is any injury or other trau once. Carlton Heckler.Jr -son 8934 Kilkenny Circle-Perry Hall, Maryland 21236 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Moreland, Memorial Park Oct.5,2010 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Dent Physician/ a Probable Myseardial Infarction disease or condition resulting in death) within 24hrs Medical Examiner therosclerotio years Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hupertension ears that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hyperlipidemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year 4 ☐ Pregnant g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia, Chronic Obstructive Lung Disease, Depression 1 Yes 2 No 3 Probably 4 Unknown History of Cerebrovascular Accident, Osteo porosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Parkinson's Disease Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ₺ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Tyes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined rectitioner Medical Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Minhelle E. Kalender CR R097104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NP Genesis Multimedical Center 7700 York Rd. Towson, MD 21204 E. Kalender CR State

M DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 25, 201011:21 PM M Physician/ Charles B. Harding Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 1 X M 2 D F Months sept 4, Year) 936 Mary land 217-32-4442 74 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Prince George's Hyattsville 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 20782 USA 4907 Eastern AVenue #215 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black White etc à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: white "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumests. Elementary/Seconday (0-12) College (1-4 or 5+) office Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Debbie Ruth Harding <u>Albert Vernon Harding</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4907 Eastern Avenue Hyattsville, MD 20782 Kathy Ricks/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Sevice State Anatomy Board 655 W. Baltimore Street MD Baltimore. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCER Immediate Cause (Final LUNG Physician disease or condition resulting in death) Medical Due to (or as a consequence of) OBSTRUCTION Examiner Bower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for ea a nonsequence of: COPID the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician and the for use as the burial Physician/Medical PREUMONIA Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown as been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1221PHERA 2 🗌 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 hpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Example 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettiying Prijaction: 10 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 2010 of death (Item 23a) (Type, Print) 7600 CARROW A

State Registrar 0 5 2010

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Day Physician/ 09Month 20 To Handon 6:23 A William M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 3305 Ryan Drive Suitland 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year **Funeral** 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Months Days Hours 1932 North Carolina **Director** 578-40-9286 78 June Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Suitland [] 1^X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3305 Ryan Drive 20746 IISA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 K Yes 2 7 No - 1952 If Yes, Give 1950 - 1952 Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black "natural" Specify: 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Contract Compliance Officer Federal Government years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ဂ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. George Handon traumatic Monnie Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen F. Handon/Wife 3305 Ryan Drive Suitland, MD 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 10/08/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityMarshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure, List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Metastatic Male Breast Cancer vears Medical Examiner Due to (or as a consequence of): Sequentially list conditions, Examine il any, leading to immedi cause. Enter Underlying Due to (or as a consequence or). Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral invertal director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2XX No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 TNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 15185D.C. 09/30/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St

DHMH 17 Rev 7/2009

Registrar

John E. McKnight, M.D.

31. Date filed (Month, Day, Year)

2. Registrar's Signature

106 Irving Street N.W., Suite 2200N Washington, DC 20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZO 0140 Hickm av Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Manyland Medical Center Baltimore, Maryland 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 - F Hours Min. 03/20/1942 Washington, DC Director 577-54-5352 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Upper Marlboro 1 √ Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10507 Pookey Way 20774 IISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black. White, etc þ 1 Never Married 2 💂 Married ¥ Yes 2 □ Nq 964 - Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 1966 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Labor Senior Program Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gladys Harris Edwin Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Wallace-Harris/Wife 10507 Pookey Way Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 10/05/2010 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary disease or condition Medical resulting in death) Due to (or as a conse unce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events subtitions of the conditions of the conditions, if any, leading to immediate cause of the conditions of the c Examiner Due to (or as a consequence oi). attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s autopsy performe death? this certificate 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ည 1 🗌 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Director; / Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in manufacture in manufacture. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signatu and title of certif 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mitika Patel Medicne

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 1 perphys. G910, 12/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6'-00 AM Physician/ Harrod A.K.A. George Deshields September George 19 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BLUEPOINT REHABILITATION CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Country) MD **Funeral** Months Days Hours Min. 1 X M 2 □ F JULY 20217-38-4696 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10h County 10a, State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 XYes 2 ☐ No BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21215 3803 CHATHAM RD. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or þ BLACK Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) RACECOURSE CHEF 12TH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ HELEN E. BROWN WILLIAM HARROD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sliment of Health a tant: If item 27 i 3803 CHATHAM RD., BALTIMORE, MD <u>212</u>15 ERICA CARTER/DAUGHTER Baltimore, 20c. Location - City or Town, State 20b. Placa of Disposition (Name of 20a. Method of Disposition Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 09/23/2010 HANOVER, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that gaused shock, or heart failure. List only one cause on each line Interval Between Onset and Death Alzheimers Dementia Immediate Cause (Final End-Stage Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Day Year in the past 12 months? 1 Yes 2 No To the Hospital or Attending Physician: The law requires that the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be lirector, page 2 s death? 2 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work s after death. 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in t within 24 hours a

To the Funeral D

completed filled i Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The Certifying Proposition in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MSRajnpameM.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NS. Rajapa (CR, M.D. 2835 Smith AV - 5-203, Bultimore, MD, 21209 State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20 To Houston Handley 12:55AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 1510 Eastway 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min April 18,1913 97 233-07-1218 Director Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1510 Eastway U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Tes 2X No Specify. Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Proofreader Federal Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eventone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alexander Remington Handley Stella Luma Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD Mr. Stephen S. Handley / Son 21146 225 Kennedy Court 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 2010 Glen Haven Mem. Park Glen Burnie, MD 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD 21. Signature of Funeral Service Licensee Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner f any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a conseduence un Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death Unknown g [] Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital 2 🗆 🗘 Other: ၉ 1 Tes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA \$ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1/Natural 5 Pending injury 1 Yes 2 No nours after death neral Director; A I filled in by the fo 2 Accident 3 Suicide Investigation 6 Could not be Place of hury - At home, farm, street, factory, office building, etc. Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide within 24 hours a

To the Funeral I

completed filled Medical 1 Certifying 29a. Certifier Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical E aminer nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying N est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

8+1

State Registrar 30. Name and address of person who completed

NAHABSTC

DHMH 17 Rev 7/2009

death (Item 23a) (Type, Print)

32. Registrar's S

0-07349 Paul Bealty Harl	•		pe or Print i tate of Maryl	and / Depa		f Health ar					201	0	31121	
Physicia		Registrar 1. Decedent's Name (First, Midd	dle,Last)		incate of	Death			2. Date of D	Reg. No eath			3. Time of Death	
Medical Exami										Month Day Year September 24, 2010			1545 hrs	
		. 4a. Facility Name (if not institution, give street and number)					4b. City, Town, or Location of Death			4c, County of Dea Harford				
		39 Priestford Road	Churchville					place (State or						
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. la	• • •	If Under 1 Ye Months Da		er 24Hrs. Min.	1			Foreign		
Director		218-32-8066 Usual Residence of Decedent	1XM 2 F	80	Yrs	5.			May	20,	1930	Cour	My) PA	
Maryland 28a-f show any d at once.		10a. State 10b. County		10c. City,	Town or Locat	ion						1	10d. Inside City Limits	
	닐	Maryland Ha	Chi	Churchville							1 Yes 2 X No			
Maryla 28a-f d at o	Director	10e. Street and Number		10f. Zip Code	10g. Citizen of What Co				ry?					
th the Maryland 23a or 28a-f sho notified at once.		39 Priestford	2102			USA								
th wit tems 2	Funeral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces? 1 Yes 2 No				as Decedent of H es, specify Cuba					an Indian, Black,			
er dea	To Be Completed by		Yes 2 X No specify:				Specify: White			-0				
urs aft tural" amine		15. Decedent's Education (Spe	vorced If Yes, Give Ye or Dates: ecify only highest gra		16a. Deceder	nt's Usual Occup	ation (Give	kind of wo		16b.	Kind of Bus			
72 hor n "na		Elementary/Secondary (0-12) College (1-4 or 5+)	during m	ost of working lif	fe. DO NOT	use retire	ed)					
5-0036 red within 72 hours a fygiene. other than "natural the Medical Examin			4		Far	mer					Dairy	Farr	n	
15-C filled v I Hygi sd oth		17. Father's Name (First, Middle		18.Mother's Name (First, Middle, Maiden Surname)										
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygeine. 77 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.		Paul Beatty Harlan Sr. Katharine Louise Baxter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat										Zip Code)		
and 2 shou fealth and N		Louise H. Umba	rger / Sis	ster	706	Glenvil	le Rd	., a	nurchy	rille	e, MD	2102	28	
e, MI and 2 :: Health 8 Fitem 27		20a. Method of Disposition		20b. P	lace of Dispos rematory or ot	sition (Name of c	emetery,		Date	20c	Location - (City or T	own, State	
MOI Pages ent of int: Ii		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify Hilltop Service Corp. 9-29							-10	T	owson,	Mai	ryland	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signature of Fundral Service Livensee 22. Name and Address of Facility McComas Funeral Home, P.A.										-		
	_	murla 11	mil		1 1	1317 Cok	eshur	v Rd	. Ab	nad	on, ME	210	009 Approximate Interval	
Physician * /Medical	Physician (Medical 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sfailure. List only one cause on each line.								arrest, si	lock, of fical		Between Onset and Death		
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	iner	Sequentially list conditions,	b											
		if any, leading to immediate cause. Enter Underlying Cause												
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Box 68760, e death certificate bette attending physical for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in	tal death 3				23d. Date of delivery Month Day			y Year				
Ox 68: ath certifi attending or use as	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)												
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tal Recc cian: The lav certificate ha	Be	25. Was case referred to medical	al I			26 Play	ce of Death	(Chack or		2 🗸	No 1	Yes	2 No	
Vital ysician his cert directo		examiner?	Hospital: 1	Inpatient 2	ER/Outpatient		Other ₄		Home 5	Resid	lence 6 🗸	Other: 8	Scene	
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	7: 70	27 Mapper of Doub 280 Data of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred												
ision Attendin or death. rector: A by the fu	Certification:	1 Natural 5 Pending Pro(Nonth: Day, Year) FOUND: 1 Yes 2 No Sep 24, 2010 1500 hrs								Subject inhaled exhaust fumes				
ivision or Atten after death Director:	tiţi	3 V Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.							28f. Location (Street and Number or Rural Route Number, City or Town, State) 39 Priestford Road, Churchville, MD					
Dj spital hours a neral I	Çer	4 Homicide		Garage										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execuvithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial - tr		(Check only	Physician: To the be aminer: On the basis and manner.	of examination an										
To t with To t	Medical	29b. Signature and title of certific	29c. Licer		29d. Date signed (Month, Day, Year)									
0		///	0.0		September 25, 2010									
OCME		30. Name and address of gerson who completed cause of death (Item 23a)												
		Mary G. Ripple MD.	Deputy Chief			1 Penn Stree	et, Baltim	ore, MI	21201					
		31. Date filed (Month, Day, Year, OCT 0 5 2010	32. R	egistrar's Signatur	e									
Regist	16I	VIUZGUIU /	Market !	7 BALL				_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ Month Year 201 10:43 RM Gloria L. Hastings October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 114 B W. Melrose Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** or bill. oth, Day, Yei 1 - M 2 XF Months Days Min. (Month, Da Hours New York Director 060-14-5706 1922 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a o Examiner must be Funeral 114 B W. Melrose Avenue 21212 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Studies should be filed with and Mental Hygier 7 is marked other t Professor Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alfred George Limberg Hermine Schwabe t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Dr. John Brown / Husband 114 B W. Melrose Avenue Baltimore, MD 21212 permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t Baltimore, 20a, Method of Disposition 20h Place of Disposition (Name of Date Oct 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 04 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 22. Name and Address of Facility
Cremation and Funeral Alternatives Signature of Funeral Service Licenses Relbox 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 2 No 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accide 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 1056239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERONIC 4 200East 33rd Street Ste650 Balto.MD 21218 31. Date filed (Month, Day, Year) **OCT 0 5 2010** State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 452 AM Terry Wayne Horrell 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Country) Rosedale FRANKLIN Square Hospital 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F Months Days Hours Min. 61 244-78-3371 North Carolina 09/16/1949 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience aust by notified in 1 ☐Yes 2 No Director Baltimore Middle River Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 414 Waters Watch Court 21220 United States Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White ģ 3altimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Disabled 12 should be filed with and Mental Hygier
7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harlee B. Horrell Addie Mae Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health ar Important: If item 27 is any Injury or other trau Delores Novak Webb - Niece 414 Waters Watch Court Middle River, Maryland 21220 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 10/02/2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Immediate Cause (Final Infarction **Physician** myocardial disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner pertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed P. 0 Due to (or as a consequence of) burial Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. the 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>≽</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed After this certificate funeral director, pag 2 No 1 □Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

FRANKLIN SQUARE DR BALTO Md 21237

30. Name and address // person who completed ca // of death (Item 23a) (Type, Print)

9000

32. Registrar's Signature

KO

31. Date filed (Manth,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ 2: 20 PM Detober larold 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltolmore brthwut If Under 1 Year If Under 24 Hrs. 8, Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Sex 1 X M 2 🗆 **Funeral** Min. Months 11*9*927/1929 MD 80 Director 217-26-4740 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important; if item 27 is marked other then "---any injury or other then "----10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Tyes 2 X No BALTIMORE MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21244 3617 KENMAR ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11, Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married Š 1 ☐ Yes 2 🛣 No WHITE If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PAPER CUTTER PRINTING Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ည **HEFFNER** ETHEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KATE HEFFNER/WIFE 3617 KENMAR ROAD, BALTIMORE, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BETH EL MEM. PARK 10/03/2010 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Ser 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Pnysician/ Ameroscerotic Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause, Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? 2 No certificate 1 Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 YER/Outpatient 3 I DOA ည 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director: After this funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury **V** Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated medical zaminier. Of the basis of examination and messagation, in my opinion; death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier M.D. D0071045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court Road Randallotons, Maryland State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death September Year 2016 Physician/ Virginia B. Hines Medical b. City, Town, or Location of Death Bolhmore Cit 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 0% BOYHMM N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) 1 □ M 2 □X Hours Country) 87 212-29-3959 VA Director 14/23 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director N/A Baltimore 28a-f MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 21128 USA 23a 9606 Haven Farm Rd-Apt. C items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. and Mental Hygiene. is marked other than "natural", or þ 1 Never Married 2 Married Yes 2 X No Specifrican 1 Yes 2 No Specify: If Yes Give 3X Widowed 4 ☐ Divorced Completed Year or Dates Amer Maryland 21215-0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mid-Harbor Elementary/Seconday (0-12) College (1-4 or 5+) Seamstree Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cora Wilkes George Wilkes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9606 Haven Farm Rd-Apt.C, Perry Hall, MD 128 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Larry Hines Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/6/10 Balt. County,MD Druid Ridge Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. 21. Signature of Fineral Vivice Licer CloseF.Svs,PA MD 21206-5105 Belair 5126 Rd, Balt. 23a. Part 🗜 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between The and Beath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year ģ Day Pregnant at time of death 2 No 1 ☐ Yes 2 to 9 ☐ Unknown the detached Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No certificate Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) September 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Baltimore 31. Date filed (Month, Day, Year) ar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Physician/ Ihle 2010 Lee 7:10 p M Dolores Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner N/A Baltimore Lorien Frankford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 07/11/1945 ear) 1 🗆 M 2 🕱 F Hours MD 65 Director 215-44-0220 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore MD N/A 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21214 U.S.A. 3215 Batavia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Forces þ 1 M Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify: Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Mercy Hospital Volunteer 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ဝ permit. Page 1 and 2 should be Department of Health and Mente. Important: If item 27 is marked any injury or other. Baker Ihle Barbara Jacob 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3215 Batavia Avenue, Baltimore, MD 21214 Mary Lafferty, Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10/04/2010 Baltimore Maryland Baltimore National 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ ☐ Unknown sate has been signed by the a page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director. After this certificate has autopsy death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death Check only one) Be examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ Nursing Home 5 Residence 6 Other (Specify) Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury work? Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on e and title of certifie 29b. Signatu completed cause of death (Item 23a) (Type, Print) nd address of person strar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month Physician JOSE V. FLORES IRAHETA 22:38 9 24 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PARK If Under 24 Hrs. **MONTGOMERY** WASHINGTON ADVENTIST HOSPITAL TAKOMA 9. Birthplace (State or Foreign 5. Social Security Number 219 - 64 - 1336 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days EL SALVADOR **Funeral** Months Hours Min. 1 (x) M 2 □ F 63 Yrs. 2/26/1947 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County items 23a or 28a-f show the Medical Examiner must be notified at 1☐Yes 2☐No PRINCE GEORGE' GREENBELT Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20770 SALVADOR 5902 CHERRYWOOD TERR. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give' Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 jo, 1 XYes 2 □ No Specify þ HTSPANIC 3 ₩ Widowed 4 Divorced EL SALVADORIAN "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PAINTER PRIVATE 12th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSEFA VICTORIA IRAHETA PEDRO PABLO FLORES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11401 MILLPORT CIRCLE GERMANTOWN, MD. 20876 CHRISTINE DELCID/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Neurial 2 Cremation 3 Removal from State 10/1/2010 LAUREL, MARYLAND 5 ☐ Other (Specify) 4 ☐ Dogation NATIONAL CEM. 22. Name and Address of Facility CAPITOL MORTUARY Funeral Service in nsee 21. Signatare 1425 MARYLAND AVE NE WASHINGTON, DC 20002 23a. Par 1. Enter the disease, or conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or yone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac /Medical Due to (or as a consequence of): Examiner onsestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due t (or as a consequence of) Examiner the death certificate be executed atus post stent pigcement ronary artery and burial-tran Due to (or as a consequence of): Box 68760, ned by the attending physician detached for use as the buria Physician/Medical igbetes melletu 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Tyes 2 No 3 Probably 4 donknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 HV0 2 🗔 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1√10 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 68005 September 27th 2010 22 voradi MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park MD 20912 Objadi 32. Registrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Physician/ Year Jones Mildred 2010 4:00a. 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Owings Mills, Biehl Ct. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 1 🗆 M 2 💢 F Months **Director** 219-12-527 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Owings Mills Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21117 Biehl 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married ğ 🗌 Yes 2🛴 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Domestic 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ပ္ Emma Smith George Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Biehl Ct., Owings Mills, Md 21117 Edgar Jones-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 10/8/2010 Woodlawn MD 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Sin atu e of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, baltimore, 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Priysician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or iinjury executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Jed Ded the signed by t Id be detach Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ been signal 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 page 2 certificate has 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify, Hospital: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu death. Accident Investigation Suicide 6 Could not be 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. ☐ Homicide determined City or Town, State) Medical 1💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature title of certifier 00071287 Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Ste 4105 Baltmore, MD 21204

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month 09 2010 30 Glen C. Jackson 2201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Olney Montgomery General Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** M 2 D F Days Country) DC Months Hours Min. 08 26 579-78-7832 53 Director Usual Residence of Decedent 23a or 28a-f show ast be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ural", or items 23a I Examiner must b 1900 Rainbow Drive 20905 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or <u>გ</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes. Give 3 Divorced Black Completed Year or Dates Il Hygiene. other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 2 years Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Neff Rental Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Johnson Thomas L. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Jackson/Wife 1900 Rainbow Drive, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 10/08/10 Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th Street NW, Washington, DC 20011 mma 23a. Part 4-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Arrhythmia 30 minutes Medical Due to (or as a consequence of): Examiner Years Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or se a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Year 5 Other (specify) Day the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available 24a, Was an certificate has autopsy performed? Yes 24 No prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) မှ 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 ☐ Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No injury 5 Pending within 24 hours after death To the Funeral Director: A Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, upleted filled in by determined City or Town, State) Hospital Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d, Date signed (Month, Day, Year) H0061316

Registrar

OHMH 17 Rev 7/2009

State

18101 Prince Philip Dr., Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael B. Williams D.O.

OCT 0 5 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #27 Per Phy G908 10/05/10 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 Physician/ B Kwash Kenneth September 11:54AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Apt #401 Howard 5633 Columbia Road Columbia If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Mary land Min. 1 🔀 M 2 🗆 F November 21° 1958 212-68-6698 51 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 U.S.A, 5633 Columbia Road Apt#401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 K Married 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Healthcare Physical Therapist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Barbara Horwitz Herbert Kwash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2073 Cresent Moon Court Woodstock, Maryland 21163 (Wife) Shiree Kwash 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-3-2010 Olney, Maryland Norbeck Memorial Gardens 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Diabetes Mellitus Immediate Cause (Final Physician/ Y Pe disease or condition ↓ Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No sate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death Unknown a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗷 No 3 🗌 Probably 4 🗌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗷 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \square Nursing Home 5 $href{Sherity}$ Residence 6 \square Other (Specify) 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☒ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1XXNatural 5 Pending injury Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eptember 28 2010 D62426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia MD 21044 410 Suite Charter ive DT 32. Registrar's Sign 31. Date filed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 October 6:40pGian Kaur Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Stella Lutherville-Timonium Baltimore Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex Country) India Funeral 1 🗆 M 2 😾 F Days Hours Min. (Month, Day, Year) Feb. 6. 1958 52 Director 170-80-0695 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Director 10c. City, Town or Location 1 Yes 2 No Maryland Baltimore Nottingham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 3 Margery Court India Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 No 21215-0036 Specify: Asian Indian 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Singh Gill Amar Harbha ian Kaur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gurpal Singh Sangha, Husband Margery Court, Nottingham, Maryland 21236 Baltimore, OCTOBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metro Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10/4/2010 22. Name and Address of Facilit MacNabb Funeral Home. P.A. 21. Signature of Funeral Service Licensee Amanda Heaston 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ BREAST CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an GIAN autopsy performed? Yes 2 X No this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 3 Suiciae 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) OCT 0 5 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Charles Edward Kauffman 200 DOTOGER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ARFO. KIDERS CAM Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Date of Birth (Month, Day) 5. Social Security Number **Funeral** Year! Months Days 96 1**X** M 2□ F 217-22-5912 Yrs 1913 Maryland 18, Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Harford County Fallston Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö death with 21047 United States 3225 Ascot Lane items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 Married Specify: White Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Fire Dep Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Battalion Chief N/Α 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Annie Schelt James Kauffman ည Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) _(Wife) Mrs. Catherine M. Kauffman 3225 Ascot Lane, Fallston, Maryland 21047 timore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition ō Oct. 4, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ō Forest Hill, Maryland Evans Funeral Chapel 5 ☐ Other (Specify) 2010 4 □ Donation 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—BelAir
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee Jesu A COUR OF 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one called in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ₽ 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. W*a*s an autopsy certificate has page 2 2 No 2 LJ No 1 ☐ Yes 1 TYes Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No death. 2 Accident within 24 hours after death
To the Funeral Director;
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numb 29b. Signature and title of certifie 31 e of death (Item 23a) (Type, Print) ame and addr * s of person who completed cau 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

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Year)

Date filed (Month, Day,

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9500 M Mont 09 2010 Vernelle Beatrice Kennedy Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Manor Care Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 12 28 1 □ M 2 🔏 F Country) Director 251-32-1059 89 S.C. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f showing or other traumatic event; the Madical Examples 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20002 48 Gerard ST. NE USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married by 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 No Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) |Medical Industry 12th grade Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Ella Heigler Moses Darby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1646 Varnum Pl. NE, Washington, DC 20017 Herbert Kennedy, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Ft.Lincoln Cemetery | 10/02/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall March Funeral Home 21. Signature of Funeral Service Licensee 4217 9th St. NW, Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Pressure Sore Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057124 10/11/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Rockville, MD 20850 Truong Bao MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ <u>2</u>010 Рм 5:15 Eric Linden Victor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Apt. 2-D Baltimore 6605 Walther Avenue Birthplace (State or Foreign Country)
 Manay Land 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days 1 🛛 M 2 🗆 F Months Hours 12-19-1962 ar) Maryland 213-88-1867 47 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a -f show any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21206 6605 Walther Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes. Give White Completed 3 Widowed 4 Divorced Year or Dates. 16b. Kind of Business Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Ligistics Forklift Operator 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hannelore W. Shultz Vitas Linden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Linden - Wife 3810 Perryhurst Place Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 10-05-2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road 22. Name and Address of Facility 21. Sign Jury f Funeral Service License Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): homa month **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events. Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the s should be detached q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has funeral director, page 2 autopsy performe 1 ☐ Yes 2 ☐ No 2 🛮 No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 🗆 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 Yes 2 No Investigation Accident after death Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Cao O air 30 Name and address of person who completed cause of death (Item 23a) (Type, Print SQUARE DRIVE STE 2200, 9163 RAO FRANKLIN UMAN 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 30, 2010 Physician/ 3:35 Robert Ellingboe Loew Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1av 9, 1945 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 🛛 M 2 🗆 F Director 65 Wisconsin 396-42-2892 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23° --- any injury or other traumatic event, the Medical Concession of the marked of the Medical Concession of the marked of the Medical Concession of the marked of the Medical Concession of the 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location Director 1 ☐ Yes 2 X No Montgomery Germantown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20876 United States 19205 St. Johnsbury Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Computer Information Information Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ruth Jaeger Jack Loew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20876 Nancy M. Loew / Wife 19205 St. Johnsbury Lane, Germantown, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium. Inc. 20a. Method of Disposition 20c. Location - City or Town, State October 4, 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 ROBERT A. Fumphrey Funeral Home, Rockville, I 300 W. Montgomery Avenue, Rockville, MD 20850 Signature of Funeral Service Licensee Haran M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury I by the attending physician and stached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: <u>ء</u> 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify) Hospice after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Sulcide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Efertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R115108 10

State
Registrar

DHMH 17 Rev 7/2009

1305 Piccard Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP,

Diane Ruckert,

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 <u>Jane Ellen Miller</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges <u>Doctors Hospital</u> anaham 7. Age (In yrs. last birthday) Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Hours Min Director 217-30-1146 76 1934 Washington, D Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince Georges Lanaham 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 6609 Cipriano Road 20706 . A 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Plumbing&Heating Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Naomi Rae Jenkins</u> <u>Benjamin Krick</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard R. Miller/Husband 6609 Cipriano Road, Lanaham, Maryland 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, Inc. 10-4-10 | Hanover, Maryland Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner UN Sequentially list conditions, Examine Due to for as a ponsecuence of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ξ Month 1 ☐ Yes ∠ . 9 ☐ Unknown detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 2 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 D Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MDD 30858 10-01-10 of person who completed cause of death (Item 23a) (Type, Print) Road Lanham Mary land 20706 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 09 Physician/ Wilhelmina Marshall 21 2010 3:09 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea March 20, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Country)

W Jersey 1 □ M 2 X F Hours 244-38-3231 Director 92 1918 New Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director MD Prince George's District Heights 1X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1207 Addison Road apt.#155S 20713 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Black. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Bolling Air Force Base Hospitality Supervisor years Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ည Spurgeron Walker Nanna Campbe 11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Marshall/Daughter Ely Place S.E., Washington, DC 20019 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Harmony Memorial Park09/29/2010 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 Freder 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Priysician/ a Gastrointestinal Bleeding disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dissemenated Intravascular Coasulation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of: Urinary Tract Infection attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 🗌 Yes Septic Shock Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hypocalcemia has autopsy page 2 death? performe 1 Yes 2xxNo this certificate 1 Yes XX No Cardiopulmonary 25. Was case referred to medical Arrest funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: မ 1 🗌 Yes 2 🖾 No 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier

Registrar

7

State

Marshul

Wilhelmba

7525 Greenway Centur Drive Greenbelt, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VERMA

31. Date filed (Month, Day, Year) OCT 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Mccall September 1:01 A 27,2010 Monica /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner baltimore Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🙀 F Vrs 58 52 05 MD Director 213-58-3083 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed an once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Y□Yes 2□No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21201 Street Apt 9E Funeral 1027 Cathedral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ∐Yes 2 XNo Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled Disabled 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) Unknown Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type. Print) 4107 Garrison Blbd 3rd Fl, Baltimore, Md Kelleen Jones-Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md 10/9/2010 On-Site 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, nature of Funeral Service L 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 his certificate his director, page 1 ☐Yes 2 ☐No 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this of funeral direction Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier S. JALALI, MD 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N Noife Street Baltimore, MD 21287 32. Registrar's Sign

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (in not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death KOMA 8. Date of Birth (Month: Day, If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🖫 F Director items 23a or 28a-f show ler must be notified at 10a. State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside Ciţy Limits Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner "natural", or 1 Never Married 2 Married þ 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY OF TAXATION STATE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NELLIE WELLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON CHARLES W. Mc NAMARA 6800 PRINCE GEORGE'S AVE. TAKOMA PARK MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 2010 BELTSVILLE MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 28 App a factors of facility of Cremation Services 933 Gist Ave., Silver Spring, MD M00382 Lolun Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical o (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day ☐ Pregnant ☐ Unknown Pregnant at time of death g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 1 Tyes 25. Was case referred to edical examiner? **Division of Vital** 26. Place of Death (Check only one) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: *Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifie 30. Name apel address of person who completed death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death t's Name (First, Middle, Last) 1. Decede 2. Date of Death 3. Time of Death Physician/ Month UGH ZOSAM Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death 4b. City, Examiner BALTIMOR ALTIMORE WICR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 9, 1943 7. Age (In yrs. last birthday) 67 Yrs. 9. Birthplace (State or Foreign Funeral Country) Maryland 1 □ M 2 😾 F Director 212-42-4570 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No <u>Maryland</u> Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 308 Lambson Court United States death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 🗆 Never Married 2 🔀 Married "natural", or þ ☐ Yes 2 🔀 No Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemakeı Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Sies Mildred Sherfey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard M. Paugh, Husband Lambson Court. Middle River. Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🔲 Removal from State any injury or 10/1/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematory, Inc. Metro 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) ING Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 inding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Pregnant at time of death 5 Other (specify) g 🗌 Unknown the 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaced use contribute to the cause of death? Completed by OBSTRUCTIVE PULMONARY DISPASE Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician; The law autopsy performed Yes 2 page 2 certificate 25. Was case referred medical examiner? funeral director, Be 26. Place of Death (Check only one) Division of Vital Hospital: 202 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After Natural 5 Pending iniury To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name a address of person who completed cause of death (Item 23a) (Type, Print) 120m W 32, Registra State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#12 18perFH, G908, 107, 5720 10, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 06:00 Physician/ 2010 September 29 William Morgan Poole, Sr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Darlington 3327 Dublin Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex. 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month 1923) C. 19, 1923 Min Florida 86 Yrs 220-03-8445 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State with the Maryland notified at Director 1 ☐ Yes 2X No Harford Darlington Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò or than "natural", or items 23a or the Medical Examiner must be U.S.A. Funeral 21034 3327 Dublin Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 1940 If Yes, Give 1961 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Specify: White Baltimore, Maryland 21215-0036 Specify. Year or Dates. 1961 1961 3 🗌 Widowed 4 🗆 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education permit. Page 1 and 2 should be filed within 72? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event "to once." (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Civil Service Dept. of Army (Government) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Laura Fable Artie Raymond Poole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3327 Dublin Road, Darlington, Maryland 21034 Mrs. Ethel Poole (Spouse) 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 🏅 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Oct. Det Evaris Funeral Chapter Place)
Bel – Air Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — B 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature funeral Service Licensee 23a. Part 1. Enter the disease, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only or e cause on each line. Approximate Interval Between set and Death Immediate Cause (Final pranuc veos onysician/ disease or condition resulting in death) Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence off. attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death certificate has been signed by the a irector, page 2 should be detached to 1 Urknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 K Residence 6 Cther (Specify) 2 No ဝ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 25 Ó 10 ddress of person who completed cause of death (Item 23a) (Type, Print) Fee State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 5:50 P M 18 2010 SEPT CLIFTON LEROY PHAIR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) 940 Days Hours Min Month, Day, Country) 1 🛛 M 2 🗆 F MD Director 69 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 XYes 2 No BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Funeral items 23a USA 5220 YORK RD. - APT. 21212 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No Black White etc ö 1 X Never Married 2 Married þ BLACK Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED SILVERSMITH 12TH 1 and 2 should be filed wit of Health and Mental Hygiel item 27 is marked other? other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည CORNETTE McCLEOD RAYMOND PHAIR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr MDBETTY BURNETTE/SISTER 1216 WINSTON AVE. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/23/2010 HANOVER, MD 21. Signature of Funer | Servic | censee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. Velster 21231 BALTIMORE, 2007-09 EASTERN AVE. Part 1. Enter the disease, or complications that caused shock, or heart failure that only one cause on each line ediate Cause (Final ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): the burial attending physician Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown signed by the at d be detached for P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 No certificate 1 🗌 Yes 26. Place of Death (Check only one) **Division of Vital** Hospital or Attending Physician: director. 25. Was case referred to medica Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Tes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending Natural 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) 29b. Signature and title of certifie 205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chules Buc

DHMH 17 Rev 7/2009

State Registrar 32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea Physician/ Month Forestine Patrolt 9:40 A M 2010 Actober Medical 4a. Facility Name (if not institution, give street and number) of Death Ba**ltimor**e 4b. City, Town, or Location of Death Examiner Randallstown Seasons Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min Year 517-22-6311 **Director** -18-1922 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Windsor Mill 1 Tes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r Funeral 21244 USA with 7405 Brixworth Court # 101 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: African-American 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th Principal Clerk Typist State of New Jersey Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Slaughter permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Mary Bell Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7710 Del MOnte Drive, Raleigh, NC 27613 Susan D. MCCormick-Holmes/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-4-2010 Baltimore, MD Metro Crematory 22. Name and Address of Facility Wile Fineral Home P.A. of Balto. Co. Sign Jure of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 Part) I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-stage Parkinsons Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate
Enter Industry
Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 🗹 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accidem
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSKy upake NID 00057465 10/3/10

DHMH 17 Rev 7/2009

State

Registrar

Smith Av. 5-203, Baltimore, 4D. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S Rajapakse, M.D

OCT 0 5 2010

31. Date filed (Month, Day, Year)

2835

32. Pegistrar's Signature

Baltimore, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Division of Vital Records, P.O. Box 68760 Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ungenethal , M.D. DOD44018 10-04-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CIBMC 6565 N. Charles St EUGENE 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

	F	- For State				tificate of	Death		Re	g. No. 2	10	31147
Physician	"	1. Decedent's Name (First, Mi Henry John		Rivoro					2. Date of Death Month September	Day 15, 2010	Year	3. Time of Death 1955 hrs
alcai Examine		4a. Facility Name (if not institu			er)	- 4	b. City, Town, c	r Location of Death	Осртопівс		nty of Death	
		108 Old Town Aven	ue				Gaithersbu				gomery	
Funeral Director		5. Social Security Number	6. Sex	7. / / 2 F	Age (In yrs. Ia 26	st birthday) Yrs.	If Under 1 Ye Months Da		-		Foreign	hplace (State or E1 Intry) Vadour
w any	_	Usual Residence of Decedent 10a. State 10b. Cour	y		10c. City,	Town or Locati	on					10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	힑		tgome	ry		German	town		Lic	a Citizen of	What Coun	X
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 19515 Fred	erick	Road				20876		-	Salvad	
215-0036 be filed within 72 hours after death with the Maryland nutal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	ᇹ	11. Marital Status		12. Was Decede Armed Force	s?		s Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto		14. R		can Indian, Black,
ufter de	ᇍ	3 Widowed 4	Divorced	1 Yes f Yes, Give Year or Dates:	2X No	1 🔀	Yes 2 N	o specify: m	exican	Spec	1	nispanic _
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (S	pecify only	highest grade o				ation (Give kind of ve. DO NOT use reti		16b, Kind o	f Business/Ir	ndustry
hin 72 hou e. than "nati	Completed	Elementary/Secondary (0-1	2)	College (1-4	or 5+)	_						
d with green ther ther there	틹	8 17. Father's Name (First, Mid	lle, Last)	0			laborer	18.Mother's Name	(First, Middle, M		truct:	Lon
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medical	8	Roberto Anzo	ra					Blanca	Olinda H	Rivera		
hould hould is man	岭	19a. Informant's Name/Relation	nship (Typ	•		1		et and Number or F				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medical i	-	Frances Nata 20a. Method of Disposition	ren/	sister i	.n <u>1aw</u> 20b. P		5 Frede:	cick Aven	ue Germa Date	ntown 20c. Locati	MD 2 ion - City or	20876 Town, State
Ore ges 1 a t of H : If it		1 XXBurial 2 Crema	_	_	State	rematory or oth	ner place) Cemeter	10/	22/2010	EL S	alvad	or
timen artmen ortant	ŀ	4 Donation 5 X Other 21. Signature of Funer Serv	Specify: ce Licenst	in stat	<u> </u>	22. N	lame and Addre					
Department of the partment of	d	mald	S	Me Di	rector	St	ate Ana	tomy Boar	d 655 W	. Balt	imore ST. NE	1 Home L.L. Street Wash.DC 20
Physician	7	23a. Part I. Enter the disease failure, List only one car			ed the death.	Do not enter th	ne mode of dying	g, such as cardiac o	r respiratory arre	est, shock, o	r heart	Between Onset and
Examiner		Immediate Cause (Final diseor condition resulting in death	se a. M	fultiple Injuri ue to (or as a co):						Death
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		cause. Enter Underlying Cau	se c									
ted Insit	<u> </u>	events resulting in death) La		ue to (or as a co	nsequence of):						
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60, cate be physici he buri	ğ	IF FEMALE:		23c. If yes, out		nancy					e of delivery	
Box 6876 e death certificat the attending phy ed for use as the	ian/	23b. Was decedent pregnant past 12 months?	n the	1 Live birth	at time of dea	~ 🖵	tal death 3 her (Specify)	Ectopic pregna	ancy	Mont	th D	Day Year
SOX death be atter of for u	Physician//	1 Yes 2 No 9	Jnknown	9 Unknown		5 Of	ner (Specify)					
that the d ned by the detached		Part II. Other significant cor	ditions	contributing to de	eath but not re	esulting in the u	inderlying cause	given in Part I.			_	the cause of death?
signe albe de	d by											ably 4 Unknown
ords, P	Completed								24a. Was autop	sy		topsy findings available completion of cause of
Sec The la	ĕ								1 Yes	2 No	1 Ye	s 2 No
Vital Rec	8	25. Was case referred to med examiner?		ospital:		ED/0 111		Other Nursir		Posidoneo	6 🗸 Other	Scana
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the reafter death. al Director: After this certificate has been signed by left inheral director, page 2 should be detach.	의	1 V Yes 2 No 27. Manner of Death		28a. Date of		ER/Outpatient 28b. Time of I		jury at Work?	28d. Describe			Guerie
vision of or Attending Pharmacher Control of The	Certification:	1 Natural	ending	FOUND: Da	ıy,Year)	FOUND: 1950 hrs		Yes 2 V No	Jump from I	neight		
r Atte	Į į		vestigation ould not be	28e. Place o			et, factory, office	building, etc.			umber or Ru	ral Route Number, City
Divisior ospital or Attend hours after death neral Director: y filled in by the	Gaile Suicide Gould not be determined (Specify) Parking structure or Town, State) 108 Old Town Avenue, Gaitherst									Saithersbur	g, MD	
	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	xaminer;	n: To the best of On the basis of e and manner state	xamination ar	ge, death occur nd/or investigat	red at the time, tion, in my opini	date and place, and on, death occurred	I due to the caus at the time, date	e(s) and ma and place, a	nner as state nd due to the	ed. e cause(s)
5 × 5 5	اقِ	29b. Signature and title of ce		and mained State			29c. Lice	nse number		29d. Date	signed (Mo	nth, Day, Year)
	~	/ }	tifier /									
	2	Careor	1	alle	u v		0.0	C.M.E. 		Septem	ber 16, 2	010
	-	30. Name and address of per Carol Allan, MD	son who co	t Medical Ex	aminer		Street, Baltir	c.M.E.)1	Septem	ber 16, 2	010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death Octobe Physician/ 12:50 Medical Name (if not institution, give street and number, County of Death Examiner Town, or Location of Death on Medical Can Sumie nne More 8. Date of Birth (Month, Day, You Sept. 4, . Age (In yrs. last birthday) If Under 24 Hrs g. Birthplace (State or Foreign If Under **Funeral** 1950 Months Days Country) Virginia 1 M 2 7 F 577-68-8106 Yrs. 60 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis MD 1 🙀 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 1528 Lodge Pole Court 21409 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. tant: If item 27 is marked other than lury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) Restaurant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carl William Roy Anna Gianassi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
248 Lower Magothy Beach Rd., Severna Park, MD21146 Kyndle Quinones/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 3 Geo: Wash University Medical Center 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature Funeral Service /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Du Ho (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury -tran that initiated events resulting in death) Last and Due to (or as a consequence of): the burial signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Dav Year Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has page 2 performed 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Tes ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number

Registrar

31. Date filed (Month, Day, Year)

OCT 0 5 2010

(Item 23a) (Type, Print)

Page Not Found

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 30 Lillian Roy 2010 6:15p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3816 Fernhill Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 01 21 Min. 1 □ M 2**X**□ F Director 90 219-26-7844 VA Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Baltimore 1 X Yes 2 □ No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21215 U.S.A. **3816 Fernhill Ave** "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) & R Bargain Elementary/Seconday (0-12) College (1-4 or 5+) Shop Owner 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Millie Estes James Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5318 Westley Ave, Baltimore, Md 21207 George Roy-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 10/7/2010 Woodlawn Woodlawn Signal Funeral Service Licenses 22. Name and Address of Facility
March F/H West Baltimore, Md 21215 <u>4300 Wabash</u> Ave, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between TENSION ediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury Examiner Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 먇 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural ours after death. Ieral Director: A filled in by the fu 1 Yes 2 No 2 Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 20

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type

31. Date filed (Month, Day, Year)
OCT 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Peggy Sargent Royce 11:25 2010 October Medical 4b. City, Town, or Location of Death Adelphi 4c. County of Death Prince George's 4a. Facility Name (if not institution, give street and number) Examiner Hillhaven Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 06/21/1924 1 M 2 K F 86 261-30-5905 NJDirector Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location Takoma Park 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland Director MD Montgomery 1 ☐ Yes 2 To No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 20912 7005 Woodland Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify. 3 X Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Smith permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is meany injury or other. ပ Fredrick Thomas Sargent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret G. Royce, daughter 7005 Woodland Ave. Takoma Park, MD 20912 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Chesapeake Crematory 10/5/2010 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. Signar re o Funeral Service Licenses M01539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final +mysician/ disease or condition resulting in death) CEIZEBIROVASCULAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death within 24 hours after death.

To the Funeral Director, After this certificate has been signed by completed filled in by the funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PERIPHERAL ARTERIAL DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an OSTEOPEROSIS DEPRESSION autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 2 No Hospital: မှ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the pasts of examination allower investigation, in the position of the cause (s) and manner as stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title MD 055559 20770 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 GREENWAY CENTER DR 1 Homas E MO MASLEN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Date of Death 3. Time of Death Morth 3 2:55 PM **Physician** 2010 Hanse /Medical Town, or Location of Death Facility Name (If not institution, give street and number) Examiner towa tome olumbia If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Security Number 6. Sex 7. Age (In yrs. last birthday 01-03-1949 **Funeral** Min. 1 □ M 2 🔀 Months Days Hours 421-66-2770 Usual Residence of Decedent 6 Director 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State Show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, it e Medical Examiner must be neithed at 1 ☐ Yes 2 No MD Howara Columbia **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 100 If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔽 🗘 o Specify Specify: Black 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, III Father's Name (First, Middle, Last) Be ည or Rural Route Number, City or Town, State, Zip Code) olumbia, MD 21045 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (A cemetery, crematory of 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) larksville. olumbiaN 10-8-10 21. Signa re f Funcial Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCAR DIAL INFARCTION MINUTES ACUTE **Physician** /Medical Due to (or as a consequence of): Examiner MONTHS ATHEROSCLEROTIC DISEASE SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine YEARS certificate be executed AND HYPERTENTION and burial-trar Due to (or as a consequence of) Box 68760 attending physician YEARS MELLITUS Physician/Medical DIABETES the as IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year for 5 Other (specify) P.0. the detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ 1 3 Probably 4 Unknown HISTORY OF CEREBROVAS CULAR ACCIDENT. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 🗆 No 1 □Yes 1 □Yes Division of Vital Attending Physician: completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred B Hospital or Attending Ph 24 hours after death. Funeral Director: After th 28b. Time of 27, Manner of Death 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the l within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number FN 1771268 atuma Othi Nagur MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

ALI NARVI, MO-31. Date filed (Month, Day, Year) 32. Register's Signature OCT 05 2010 >

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CEDAR LANE, COLUMBIA, MD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Shield 5:15AM 0 Medical 4a. Facility Name (if not institution, give st **Examiner** Town, or Location of Death 4c. County of Death more If Under 1 Year 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** 7. Age (In vrs. last birthday) If Under 24 Hrs. Days Months Hours Min 231-07-8 88 Director an 28a-f show 10a. State 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 X Yes 2 No timore 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Cou Funeral 23a items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ack 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industri (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) tomer Be 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street ar 19a. Informant's Name/Relationship (Type 21207 borah 1ds-Keeselderopher 1733 Langtore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date cemetery, crematory or other place) Burial 2 X Cremation 3 - Removal from State 10-8-2010 4 Donation 5 Other (Specify) 7. Name and Address of Facility augho Caree 1751 Baltimore 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

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Gruchn Bldg.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 Physician/ AM September 00 SANTANGELO **JERRY** LOUIS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days Hours Min Country) 1 🛛 M 2 🗆 F Ohio 287-18-0458 89 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State with the Maryland Director 1 Yes 2 XNo Walkersville Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 56 West Frederick Street U.S.A 21793 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: "natural", White Completed 3 XWidowed 4 ☐ Divorced Year or Dates and Mental Hygiene.

'is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Craneman 12 permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, til once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Philomenia Caviano John Santangelo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) | 1813River Mist Court, Frederick, Maryland21701 Roseanne Lepri Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 10-2-10 Youngstown, Ohio Calvary Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee michae 6009 Harford Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ynd rom Immediate Cause (Final Acute Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi signed by the attending physician and doe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Month in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 1 Yes 2 9 Unknown a 🗌 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2/X No 3 Probably 4 Unknown 1 Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No page 2 1 ☐ Yes 2 ☐ No this certificate 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medical funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 \square Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 24 hours after death. e Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 MDD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th St Frederick MD 21701 400 32. Registra s Signa State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month <u>2:2</u>5 ^{P м} Physician/ Samuel Lester Shanks October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville Oak Crest Care Center 5. Social Security Number 216-16-2095 If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🛛 M 2 🗆 F 89 1921 Baltimore, **Director** MD Usual Residence of Decedent Show 10c. City, Town or Location 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Parkville MDBaltimore 1 Yes 2 XNo 10g. Citizen of What Country? 10e. Street and Number 21234 Funeral 8832 Walther Blvd. Rm 240S US.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 2 No WWII Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) PC% F. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Elsie Lee Kennard Samuel Lester Shanks, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8820 Walther Blvd. 3508 Parkville, MD 21234 Euniœ Shanks/ Wife Baltimore, October 3, 2010 20b. Place of Disposition (Name of cemetery, crematory or other Evans Funera 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 2010 RomestHill, MD 4 Donation 5 Other (Specify) Es Name and Address of Facility Vans Funeral 800 Harford Sign turn of Mineral Service Licensee 22. Name and Evans 8800 23a. Part 1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Interval Between Onsel and Death nock, or heart failure. List only one cause on each line PARKINSON'S DISEASE Immediate Cause (Final Physician/ dis se or condition ulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death ☐ Yes 2 ☐ No cate has been signed by the a page 2 should be detached a 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? After this certificate I 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ ER/Outpatient 3 DOA 1 Inpatient 2 I within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier (Month, Day, Year) T 0 5 2010 State Registrar

DHMH 17 Rev 7/2009

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	Examin				restreet and number) h Medical		ter	4b. City, Town,		on of Death Tows (חכ	4c	County of De Bal	ath timor	e	
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	show at	o	Usual Residence of 10a. State	10b. County		10c. City	y, Town or Loc	ation				<u> </u>		10d. Insi	de City Limits	
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	s 23a or	Funeral Director	10e. Street and Nui 2708	mber 6th Stree	et			10f. Zip Code	21219			10g. Ci	tizen of What (-		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ě	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2 Married	12, Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates.	?	If	Vas Decedent of Yes, specify Cu	ban, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify: W	nite, etc.	ın,	
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Ma	id 2 sh ealth ar n 27 is er trau		19a. Informant's Name/Relationship (Type, Print) Kay Sessa Wife 19b. Mailing Address (Street and Number or Rural Route Number, City 2708 6th Street Sparrows Point													
Baltimore,	Page 1 and ment of Hest and ant: If item ant: If item any or other				☐ Removal from Stat	val from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7, 2010							20c. Location - City or Town, State Baltimore, Maryla			
Balt	permit. Departr Import any inji	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dun 7110 Sollers Point Road, Dun 23a. Part 1. Enter the disease of complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest,											dalk,	P.A.	222	
			23a. Part 1. Enter shock, or hea	the disease, o cor art failure. List only	nplications that cause one cause on each lir	ed the deap	Do not ente	r the mode of dy	ring, such	as cardiac	or respiratory ar	rest,	daik, i	Appro	kimate Il Between	
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Box 687	ath certificate be ex attending physician for use as the burial		IF FEMALE: 23b. Was decedent in the past 12	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Fetal	Ideath 3	Ectopic pregna	ncy				23d. Date of o	delivery Day	Year	
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/M									24a. Was autor perfo	osy ormed?	prior to death?	o completion	ngs available of cause of	
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Divis	al or At s after o il Direc	Cer	4 Homicide	determined	28e. Place of In	jury - At hor tc. (Spec <i>ify)</i>	me, farm, stre	et, factory, office	•		28f. Location (S City or Tow			Rural Route I	Vu <i>mb</i> er,	
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical Certificate:	(Check 2	Medical Exan	ysician: To the best on niner: On the basis of rse Practioner: To the	examination	and/or invest	gation, in my opin	nion, death	occurred at	the time, date a	and place	, and due to the	e cause(s) an	d manner stated.	
	To the with To the come		29b. Signature and	title of certifier	uc			29c. Licen	se numbe				te signed (Mor		r)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Pet FH G908 10/05/10 JH State of Maryland / Department of Health and Mental Hygiene 0 1 0 For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 400 Paul Spence 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number 14 45 1.1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1₽M 2□ F Yrs. April 16,1946 Wash. £ 64 D.C. Director 227-60-0627 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Owings Mills -28a-f MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 23a or U.S.A. 21117 9505 Sidebrook Rd. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? or items 1 □Yes XX No If Yes, Give Year or Dates: 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 □ Yes XXNo Specify: White Specify: Š 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Cartography Nautical Cartographer permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygid Important: If item 27 is marked other tany Injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miriam Delores McGrail LeRoy Joseph Spence ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9505 Sidebrook Rd. Owings Mills, MD 21117 Jayne S. Spence/Wife 20b. Place of Disposition (Name of All Faiths 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial ★ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Crematory & Chapel: 10/13/10 Manchester, MD 21. Signature of the I Se de Licensee 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 record 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Manchie /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending use 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day for 1 Month Ye ar in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown -CALCULO Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1₽ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 908 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CCUPT 31. Date filed (Month, Day, Year) OCT 0 5 2010 Registrar's Signatu State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 0 3	1158
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Mever Married 2 Married 1 Yes 2 No Black, White, etc.	dian,
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o	To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
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Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director. After this certificate has been signed in by the funeral director, page 2 should be din by the funeral director, page 2	Completed	24a. Was an autopsy fir autopsy fir prior to complet delta to the second of the secon	tion of cause of
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→ F ≥ D S		29b. Signature and title of certifier SRAYPAUNUM.D. 29c. License number 70057465 29d. Date signed (Month, Day, Y)
)	at e	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. Rayupa K. R., M. D. 2835 Sm 1 Th At - 5 - 235 - Baltimore, MD. 21209 31. Date filed (Month, Day, Year) 32. Registrar's signature	
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_		1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.														
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Divi	oital or A urs after ral Dire	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or Town, State)														
	he Hosp in 24 ho he Fune pleted f	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											e cause(s) and manner stated.			
_	To t		29b. Signature and	title of certifier			·	29	RE.	number		29d. C	ate signed (Mor	nth, Day, Year)		
	5		,		completed cause of d	leath (Item	23a) (Type, I	Print)				<u></u>	to lember	28,2010		
	Sta		31. Date filed (Mont)	h, Day, Year)	rnardo 32. Registr	ar's Signat	ture back	201	Lou	Round	n Blvd	Ba	Than	c, MD21239		
	Registra	ar	UCI	0 5 2010	Cener	p.	gar	4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:35 AM Deborah Jill Self september /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Hospital of Baltimore Baltimore N/A If Under 24 8. Date of Birth (Month, Day, Aug. 23, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 ⋤ F Months Days Hours 66 Director 215-42-7751 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be natified at TVYYes 2 □ No Be Completed by Funeral Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 USA 3600 Edgegreen Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married White 1 □Yes 2 🗓 No Specify Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) Coilege (1-4or 5+) State of Maryland Unemployment Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Fyman Mc Kinniss Jean George Newlin Cushing ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 Edgegreen Avenue, Baltimore, Maryland 21211 Health em 27 i William Self Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Important: If the any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/3/2010 Glen Burnie, Maryland 21. Signature of Juneral Service Licensee Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part 1. En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythmia Physician disease or condition resulting in death) / /Medical Due to (as a consequence of): Examiner berkalemia Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner **Hospital or Attending Physiclan:** The law requires that the death certificate be executed to hours after death. Acidosis nding physician and ise as the burial-tran Due to (or as a consequence of): Physician/Medical sate has been signed by the attending page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) 1 □Yes 2 ☑No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No After this certificate 1 ☐ Yes 1 ☐ Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Man of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 687600

wheat

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

29c. License number

Battimore

29d. Date signed (Month, Day, Year)

September 30,20

			Please	State of Maryland				_				
			For State Registrar	State of Maryland		tificate of L			Reg. No.	0 31101		
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death		
	Physicia Medic		Rosalind	Scott				Month /C	Day	Year OCIC US 19am		
	Examin		4a. Facility Name (if not institution, give str				Location of Death		4c. County of Death			
	Euporol		Good Samaritar 5. Social Security Number 6. Sex		st birthday)	Baltim If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	NA NA	Birthplace (State or Foreign		
	Funeral Director			м Ж Б Ж F 46	Yrs.	Months Days	Hours Min.	06-04	, Year) -64	Country) MD		
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	the M or 28 e noti	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	nat Country?		
	with rs 23a	Funeral Director	1233 Glenwood	Avenue		2123			USA			
	r death		11. Marital Status 1 X Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?	. 13. \	Nas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. African		
920	s afte ral", o Exam	ed by	3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates.		Yes 2X No	Specify:		Specify:	merican		
21215-0036	2 hour "natu adical	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup	ation during most of work	king	16b. Kind of Bus	iness Industry		
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д 2	iled w Il Hygi other vent, t	Be	17. Father's Name (First, Middle, Last)	NA	ьаг	JOLEL	18. Mother's Nan	ne (First, Middle, i	Maiden Surname)			
ylar	ld be f Menta arked atic el	2	Thomas H.	Scott			Beatri		Scott			
Jan	shou and 7 is m		19a. Informant's Name/Relationship (Type							ate, Zip Code) 21239		
e,	and 2 Healt! tem 2 other 1		Cinseray Scott- 20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of		Date Dal		Maryland Dity or Town, State		
Baltimore, Maryland	permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I fleem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		1 ☐ KBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State $\begin{vmatrix} c \epsilon \\ A r \end{vmatrix}$	metery, cren butus	natory or other place Mem. P	k. 10-	07-10	Arbutu	ıs, MD		
ati	rmit. F spartm sporta sporta sy inju		21. Signature of Funeral Service Licensee		22	. Name and Addres	ss of Facility Wy	lie Fu	neral H	Home P.A.		
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٠.	attern a		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cations that caused the death cause ach line.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory and	est,	Approximate Int. rv. Between C. sev. L. D. ath		
	h, sician/ Medical		disease or condition resulting in death)	Due to (or as a correction	ance of):	14	, ,	-		1100		
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	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Du or a ya consequ	tice of):	ynsic	, ,			years		
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Box 6876	rtificat ling ph e as th	Physician/Medi	IF FEMALE:	c. If yes, outcome of pregnar	101							
ŏ	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No	1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	су		23d. Date Mon	of delivery th Day Year		
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P.O.	requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions con	tributing to death but not resu	ılting in the u	ınderlying cause giv	ven in Part I.			oute to the cause of death? 3 Probably 4 Unknown		
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n of	fing P	ate:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe h	ow injury occurred	d		
sioi	l or Attendi after death. Director: A I in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor			165 2 110			or Rural Route Number,		
Division of Vital Records,	tal or afters after all Dire		4 Tromicide determined	building, etc. (Specify)			h	City or Tow	n, State)			
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	Ž	only one) 3 Certifying Nurse 29b. Signature and tiple of certifier	Practioner: To the best of my	knowledge,	death occurred at the				nner as stated. (Month, Day, Year)		
	->-0		► GYVVVVI	/XI M	(D	Do	104200	P3	10-1	01-3010		
	3		30. Name and address of person who cor	mpleted cause of death (Item	23g) (Type, F	Print)	1. Hori	1/n/ F	nanua	OLAN Porh		
	Sta	to.	31. Date filed (Month, Day, Year)	2. Registrar's Signati	ure OUV	MUTICAL	10103/11	141 1	· rrieto	ency nour		
	Sta Registr		OCT 0.5 2010		6-	11	1		~	V		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Smith 2010 Richard Leon 9:18 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 8. Date of Birth (Month, Day, June 27 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min, 1925 Washington D.C. Director 85 576-28-4775 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 No MD Montgomery Chevy Chase 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 4701 Willard Ave. #1107 20815 United States Examiner must "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 1944-46 I and Mental Hygiene.

7 is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Intelligence Officer Federal Government of Health and Mental Hyg of Health and Mental Hyg fitem 27 is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Zella Kouns Ray Lionel Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 Willard Ave. #1107, Chevy Chase, MD 20815 Constance N. Smith / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hambortant: If ite any injury or ot 1 🗌 Burlal 2 🔀 Cremation 3 🗌 Removal from State 10/5/2010 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Sec 22. Name and Address of Facility Rapp Funeral and Cremation Services 20910 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Aspiration Pneumonia disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ed by the detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k þ Disecting Abdominal Aortic Aneurysm 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No certificate Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Cher (Specify) Hospice Director: After this in by the funeral di 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tyes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier 3 2010 D60634 OXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1160 VARNUM ST. NE WASHINGTON BINDY C. JOSEPH

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

OCT 0 5 2010

32. Registrar's Signature

_			For	Please	State of M		/ Depa	ırtmer	nt of H	lealth and I	-			3116	3		
3			State Registrar 1. Decedent's Nam	e (First, Middle, La	st)		Cer	tificat	e of E	Death	2. Date of D			3. Time of Deat	th		
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52	Examin	er	2 - 1	not institution, give	e street and number)	י אמסנ	e	Ba	Thi	Location of Death	ity	4c.	County of Deat	none			
ا کے	Funeral Director	1	5. Social Security N 185-46-		7. Ag	e (In yrs. last 56	birthday) Yrs.	If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth a <i>y, Year)</i> 1 24, 19	9. Bird Cor	thplace (State or Fore untry) MD	۰ ۱		
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andun 036	e filed within 72 hours after death with the Maryland that Hygiene. Atal Hygiene. At the Medical Examiner must be notified at event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status1 Never Marr3 Widowed	ried 2 Married 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.					spanic Origin? (Sp h, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, White Specify:				
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and A	ould be filed on Mental Hy, marked oth Imatic event	To Be	17. Father's Name (lfred Anthony	h			18. Mother's Nar			Maiden Surname) Mildred Piechocki City or Town, State, Zip Code) 20c. Location - City or Town, State Glen Burnie, MD					
Mar	2 shouth and the and traum traum		19a. Informant's Na Steven S	ame/Relationship (7	Type, Print) Broth					and Number or Ru		er, City or	Town, State, Zij	o Code)			
Baltimore,	W O +- F				☐ Removal from State	cem	ce of Dispos netery, crem Atlantic	atory or c	other plac		Date t 04, 2010						
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Divisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,		3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined		ury - At home c. (Specify)	e, farm, stre	eet, factor	y, office			(Street and own, State)		ral Route Number,			
(6)	he Hospital in 24 hours a he Funeral pleted filled	Medical	(Check 2	2 Medical Exam	vsician: To the best of niner: On the basis of e rse Practioner: To the	examination a	nd/or invest	igation, in	my opinio	on, death occurred	at the time, date	and place	, and due to the	cause(s) and manner:	stated.		
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				ress of person who	completed cause of c	leath (Item 23	3a) (Type, P	rint)	u 4	42 Barl	home	mo	21215				
	Stat Registra		31. Date filed (Mont		32. Registr	ar's Signatur	1. 40	ule	1	42 Bal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AFR PM dai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAYVIEW MEDICAL BALTIMORE HOPKINS CENTER 9. Birthplace (State or Foreign Country) Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth Funeral (Month, Day, 1 M 2 - F 355-42-451 Director or 28a-f shov 10b, County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 21224 U.5 A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 - Widowed 4 - Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER McDonald 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or ot BALTIMORE, HARYLAND 4 ☐ Donation 5 ☐ Other (Specify) enetery 10-7-2010 N. ZANNINO JR. F.H 22. Name and Address of Facility Toseph Signature of Juneral Service Licensee 3. CONKling St se, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Ust only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1, Enter the shock, or heart failure. Immediate Cause (Final Physician/ MESFIRATOR disease or condition HOUR Medical resulting in death) **Examiner** MONTH CAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No. 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific CCTOBER 2010 person who completed cause of death (Item 23a) (Type, Print) 4940 BALTIMOR 00N AVENUE EASTERN 32. Registrar's S

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ IRVIN OCTOBER OF SNYDER 2010 6:17 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 8 Date of Birth 7. Age (In vrs. last birthday **Funeral** Months Days Min 1**X**X M 2 □ F 88 107797192 216-12-7158 Director Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director MD BALTIMORE PIKESVILLE 1 Yes 2XXNo 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 STONEHENGE CIRCLE, #2 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. 3 🗆 Widowed 4 🗆 Divorced WHITE "natural" Specify: Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than " Elementary/Seconday (0-12) College (1-4 or 5+) INTERIOR DESIGNER RESTAURANT INDUSTRY 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ DAVID SNYDER MOLL IF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a PIKESVILLE, MD 21208 item 2 <u>SHIRLEY SNYDER/WIFE</u> STONEHENGE CIRCLE. #2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or or
once. 1 X Burial 2 Cremation 3 Removal from State HEBREW YOUNG MENS CEM: 10/03/2010 4 Donation 5 Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Signature Funeral Service Lice see 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Phermonia Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Debount Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Parkinson Disea Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 2 🗆 No 1 🗌 Yes Division of Vital completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 D Other (Specify) (+USO) CYO 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred I or Attending Fafter death. 1 Natural Director: After 5 \square Pending work Accident
Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 120010635 MD 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) N chartes 6701 31. Date filed (Month, Day, Year) 32. Registrar Signat State 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:15AM September 30,2010 Annie Ruth Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07 25 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1□M 2 F DC 78 579-40-2108 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f show notified at 1 X Yes 2 No Prince George's Director Lanham 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number a or 20706 USA item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must t 6940 Lamont Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married **Black** 1 □ Yes 2 No 5-0036 Specify. Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Federal Government EEO Investigator 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Annie McDuffy Thomas Porter ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important; If item 27 is any Injury or other trau. 6940 Lamont Drive, Lanham, MD 20706 Daryl Thomas/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/07/2010 | Brentwood, MD Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall March Funeral Home 21. Signature of Funeral Service Licensee 4217 9th Street NW Washington, DC 20011 23a. Payl . Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line.

Imm diate Cause (Final disease or condition resulting in death)

a.

Due to (or so a source with the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. Physician /Medical Due to (or as a consequence of): Examiner Dysrhythmie CArdioe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Native be executed Due to (or as a consequence of) burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pertension 24a. Was an page 2 s autopsy 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA 은 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 K. Muhad mDD52865 30. Name and address of person who correleted cause of death (Item 23a) (Type, Print) Welson M.

DHMH 17 Rev 1/2001

Registrar

Glenn

Dole

Annapolis Road Svite 200

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:58AM September TURIN JOSEPH 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** General Hospital Olney Montgomery Montgomery 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1√ M 2 □ F Months Days Hours 0671871916 Country) 94 NY Director 060-01-0990 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🗓 No MONTGOMERY SILVER SPRING MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 3700 INTERNATIONAL DRIVE death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Tes 2 No Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. NEWARK Elementary/Seconday (0-12) College (1-4 or 5+) BOARD OF EDUCATION PSYCHOLOGIST 5+e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other in other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **GESTERN** SAMUEL TURIN HELEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 11612 LEBARON TERRACE, SILVER SPRING, MD SUSAN DECHTER/DAUGHTER 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 and Decreated of Hamportant: If ite any injury or ot once. cemetery, crematory or other place) X Burial 2 Cremation 3X Removal from State MT. MORIAH CEMETERY 09/30/2010 FAIRVIEW, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ure of Funeral Service Li no e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant a 9 Unknown Pregnant at time of death 2 🗌 No should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy page 2 perform death? 1 🗌 Yes Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 2 X No Other: 1 Yes ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death. Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number September 30 2010 9inh 54996 bichhum Name and address of poson who completed cause of death (Item 23a) (Type, Print) 18/01 Frince Bichhuong inh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 3, 2010 4:15 A Verdiano Margaret Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Harford Bel Air 2212 Lyns Ct. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days (Month, Day, 1 🗆 M 2 💆 F Hours Min ^{Year} 1925 85 New Jersey 146-18-3781 Yrs. Jan. Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland by Funeral Director West New York 1 Yes 2 No New Jersey Hudson 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 07093 6008 Broadway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes. Give Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Homemaker 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rose Tuminello Page 1 and 2 should be Caspar Noto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 452 Walker St., Fairview, NJ 07022 19a. Informant's Name/Relationship (Type, Print) Mary Ann Moyer / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5X Other (Specify) Entomoment permit. Page Department of Important: If any injury or North Bergen, NJ 10-9-10 Flower Hill Maus. Signature Muneral Service License ²²Noccomas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): **Examiner** Esquentially liet our citione, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth
4 Pregnant in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 ₺ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Other: 1 🗌 Yes 2 4No 4 Nursing Home 5 Residence 6 Other (Specify ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 3:52 PM 26, 2010 Eugene Wright September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1030 E. 33rd Street #221 Baltimore | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | Days | Hours | Min. | Dec. 7, 1933 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 □ F 76 Director |213-30-6858 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Every one. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 11X Yes 2 □ No Funeral Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 United States 1030 E. 33rd Street #221 12. Was Decedent Ever in U.S. Armed Forces?
1 Xes 2 No 1955-14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∑XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: ģ 1957 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive 9 Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Edward Wright Mae E. Milburne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Felicia Wright-Dargan, Niece 5002 The Alameda, Baltimore, Maryland 21239 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/04/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of FacilitCremation Society of Maryland, Inc. 21. Signature of Funeral Service License Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. UNGESTIVE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed and use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy Month Day for in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown as been signed 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law page perform 2 No 1 ☐ Yes 2 ☐ No 1 Tyes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊿Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) SPHMDer 29, 2 29b. Signature and title of certifier 047650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH GREENEST. BALTIMORE MARYLAND STA KUPOLI

DHMH 17 Rev 1/2001

State Registrar

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			For State Registrar		J. J. C.		ertifica			Reg. No.2010 31171							
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	Director		214-88-8 Usual Residence of	3593	1 □ M 2 □ F	64	46 Yrs.	Wonths	Days	Hours	Min.)7 2	8 rear	64	Country	" MI)
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	I Dire	10e. Street and Nun				Dare.		p Code				10g. C	itizen of What	Countr		3 2 🗆 NO
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0036	urs afte tural", . al Exan	ted b	3 Widowed	4 Divorced	If Yes, Give Year or Dates.			1 🗌 Yes	2 X □ No	Specify:				Specify:	Bla	ck	
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Baltimore,	Page 1 ment of ant: If i		1 Burial 2 Donation	Cremation 3 5 Other (Spec	Removal from State	C	emetery, cre	ematory or o	other place			/2010	l	altim			E
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			23a. Part 1 Enter th	he disease, or con	nplications that caused one cause on each line	the death								re, M	1	1215 Approxima Interval Be	te
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P.0	s that th gned by re detac	by Ph	Part II. Other signifi	cant conditions	contributing to death b	ut not res	ulting in the	underlying	cause give	en in Part I.		23e. Did t	obacco	use contribute	to the	cause of o	leath?
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Whittay Division of	al or At s after or l Direct d in by		4 Homicide	determined		iry - At hoi :. (Specify)	me, farm, st	reet, factor	y, office		28f	Location (S City or Tov		nd Number or (e)	Rural R	oute Numi	oer,
,S L	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the brown in the funeral director.	Medical	(Check 2		rsician: To the best of niner: On the basis of e	kamination	and/or inve	stigation, in	my opinior	n, death occu	urred at the	time, date a	and place	e, and due to the	ne caus	e(s) and ma	anner stated.
	To the within 2 To the comple		only one) 3 29b. Signature and		se Practioner: To the	best of my	knowledge,		rred at the c. License		nd place, a	ind due to th		s) and manner ite signed (Mo			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Physician/ 3:10 P M 2010 Jean Wilder September Bernice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing and Rehabilitation Center Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7, 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2 X F 88 Director 577-26-0129 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City. Town or Location 10a. State aţ Director other traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Maryland Montgomery Derwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò should be filed within 72 hours after death with t n and Mental Hygiene. 7 is marked other than "natural", or items 23a Funeral 20855 United States 16441 Keats Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify. White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Furniture Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bertha Love Michael Hilty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. Martha Wilder Williams/Daughter 16441 Keats Terrace, Derwood, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 9, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Parklawn Memorial Park Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home / Rockville Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850 M01596 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ifeart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day cate has been signed by the atterpage 2 should be detached for a Month Year 5 Other (specify) Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 1 ☐ Yes 2 ☐ No this certificate Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner? 2 **X**No Hospital Other: 1 Yes 9 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural Accident Pending Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check erthying flurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title P TZTZ OOQ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Heshmat, M.D. 7133 Millrun Drive, Derwood, Maryland 31. Date filed (Month Day, Year) 1010 2. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per G908 10/05/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month eptember Day 29 Physician/ Year 2010 5123 **∮**M WEISSMAN ANNA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Boutimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min. 03/30/1912 SWITZERLAND **Director** 134-26-0421 98 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5929 BLAND AVENUE 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) CLERK FINANCIAL INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DANK SHEVA ABRAHAM UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muller AVERY / GRANDSON 5929 BLAND AVENUE, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) 10/03/2010 FLUSHING, NY Sign hure Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ an Hon disease or condition Medical resulting in death) as a consequence of) Examiner 80 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f 2 🗌 No g 🗌 Unknown g Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been sig 24a. Was an Were autopsy findings available prior to completion of cause of autopsy page death? 2 No certificate 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after deaun.

Funeral Director: After this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 063170 tember 29, 2010 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death OCTOBER 01 Physician/ 2010 SHARON WALLACH 12:27 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Min. 1 M 2 X F Hours (Month, Day, Year) 12/30/1957 Director 173-52-3535 PΑ 52 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the last of the l 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 121 CHARGEUR ROAD 21136 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: 3 Widowed 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CANTOR CLERGY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH WALLACH **ESTELLE GAVERN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH GIBSON / SISTER 8030 STEEPLECHASE CIRCLE, ARGYLE, TEXAS 76226 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK: 10/03/2010 | RANDALLSTOWN, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ mue tusta disease or condition rea v Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospitallor Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) the 9 🗌 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate ! Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 **X**No ၉ HOSPILA 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Tother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Investigation 2 Accident 3 Suicide 4 Homicide · irector 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 00070635 30. Name and address of person who cor eted cause of death (Item 23a) (Type, Print) Baltimore MD 21204. 6701 Ncharles St. eura Partel

J DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:01 AM October lelen 03 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner HARDON HOSP: TAL 501 hmu20 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral (Month, Day, 11/30) 1 □ M 2,**⊠** F Washington DC 212-07-9007 Director 93 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21230 1370 Andre Street USA death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 ZNo Specify: Specify: "natural", Completed 3 ₩ Widowed 4 □ Divorced Chinese the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Hostess / Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Toy Shim George Goon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard T. Yee 1236 Heritage Dr. Morris, Ill. 60450 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/6/10 Baltimore, Maryland 4 Donation 5 Other (Specify) Baltimore Crematory 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lio 3620 Wilkens Ave. Baltimore, Maryland plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Priysician/ myourdist intenc disease or condition resulting in death) Medical Due to (or as a consequence of Examiner paten CORUNARY Sequentially list conditions. ri arry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Exam law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? for Day Month Year Pregnant at time of death cate has been signed by the a page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary Hypertension -moderate 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of YULMUMMET FIBRUSIS Hospital or Attending Physician: The law
 24 hours after death.
 Funeral Director: After this certificate has Is autopsy death? nerformed' CHRONIC RENAL FAILUNE 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 🔲 No 2 Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practicals: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number

State Registrar

DHMH 17 Rev 7/2009

62. Registrar's Signature

0 5 2010

3001 South Haroven St Baltimore MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 04, 2010 6:32 P. M Physician/ Ruth Irene Ziegler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Baltimore County Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 🗆 M 2 🔀 F Jan. 28, 1923 Months Baltimore Co.MD 216-18-6149 87 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 🔀 No or 28a-f Baltimore Baltimore County Maryland Citizen of What Country?
United States 10f. Zip Code 10e. Street and Number 21206 5622 North Lane 23a "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: White 3 Midowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **N/A** Elementary/Seconday (0-12) Home Maker Own Home 08 Be 18. Mother's Name (First, Middle, Maiden Surname) **Audrey Leona Hill** 17. Father's Name (First, Middle, Last) Otto Carl Hinz, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21206 Mrs. Dorothy Helen Biemiller Baltimore, Maryland 5622 North Lane 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State (Baltimore County) Friday Gardens Of Faith Cem. Rossville, Maryland Oct. 08, 2010 4 Donation 5 Other (Specify) Signature of Funeral Service License Lifety L. Gair, Sr. Perceiul Alternatives Fureral & Cremation Center, P.A. Car, Lic. #100677 Timonium, Maryland 2325 York Road 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final obstructive lung disease Physician/ STACE recers End disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23h. Was decedent pregnant in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death 1 L Yes 2 D 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Malignant pleural effusion 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) HOSPIC P မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 💆 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier POO 70635

State Registrar

DHMH 17 Rev 7/2009

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MD

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32. Registray Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Andrew Antlitz, Jr October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1725 Bayside Beach Road Pasadena Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months July 15. 1 X M 2 \square F Days Hours Min. 1930 Maryland 212-28-2036 80 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 1725 Bayside Beach Road 21122 U.S.A. or items should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Specify: White If Yes, Give 3 🛮 Widowed 4 🗆 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Bethlehem Steel College (1-4 or 5+) Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Lee King Andrew A. Antlitz Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard M. Antlitz (Son) 1725 Bayside Beach Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 X Burial 2 Cremation 3 Removal from State 10-06-10 Brooklyn, Maryland 4 Donation 5 Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Anice Licenses 22. Name and Address of Facility McCully-Polyniak FuneralHome P.A <u>3204 Mountain Road, Pasadena, Maryland</u> 21122 art 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only of Immediate Cause (Final Physician/ disease or condition resulting in death) a menth Medical Due to or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Exam or Attending Physician: The law requires that the death certificate be executed ANTHOS Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months Month Pregnant at time of death 5 Other (specify) g 🗌 Unknown detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Tes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Hesidence 6 \(\triangle \) Other (Specify, 1 Yes 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a e of certifie 29c. License number 29d. Date signed (Month, Day, Year) 144977 419 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PASADENA

DHMH 17 Rev 7/2009

State

Registrar

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OCT 0 6 2010

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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		_	For State Registrar		state of	Marylan			nt of F te of E		and ivi	ептаг ну	giene Reg. N	2010	31178		
	Physicia Medic		Decedent's Name (First, MYNA	Middle, Last)	AGETS	TEIN						2. Date of De Month October	eath D	ay Ye	3. Time of Death or 0923 \(\Lambda\) M		
ره معدر	Examin	er	4a. Facility Name (If not inst		et and number	*			Beilt	Location	e Ci	ty	4	c. County of D	County of Death N/A		
	Funeral Director		5. Social Security Number 215-14-5309		1 2 F 7	. Age (In yrs. Ia	ast birthday) Yrs.	If Unde Months	Days	If Under Hours		8. Date of Bit 07/14/	rth ay, <i>Year)</i> 1922	g.	Birthplace (State or Foreign Country) MD		
	laryland 3a-f show iffied at	ector	Usual Residence of Deceder 10a. State 10b. C		RE	10c. City	y, Town or Loc	Location 10d. I									
	with the IV s 23a or 28 ust be not	Funeral Director	10e. Street and Number 130 SLADE	AVENUE .	, #313			10f. Zi	p Code	1208			10g. C	itizen of What	Country?		
9036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examinar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ 3 X ☐ Widowed 4 ☐ Div	Married	Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	2 LANO	- 1			ispanic Ori in, Mexican Specify:		cify Yes or No- Rican, etc.)		Black, W	Race - American Indian, Black, White, etc. ecify: WHITE		
Maryland 21215-0036	ed within 72 hou Hygiene. other than "nati ent, the Medica	Completed		ecedent's Educa r highest grade o		or 5+)	16a. Deced (Give i life. De	kind of wo O NOT us		during mosi	t of workin	g	16b. l	Kind of Busine WHOLES DISTR			
land;	should be filed wand Mental Hyg rand Mental Hyg ramarked othe raumatic event,	To Be	17. Father's Name (First, Mi				er's Name EBA	(First, Middle		den Surname) FISHER							
	Page 1 and 2 nent of Health ant: If item 2' ary or other t		19a. Informant's Name/Rel MICHAEL AGI									Route Number		r Town, State, RE,MD	Zip Code) 21208		
Baltimore,			20a. Method of Disposition 1 XBurial 2 Crem 4 Donation 5 C		moval from S	tate C	lace of Dispo emetery, cren LNGTON	natory or	other plac		10/3	-	BAI	TIMORE			
Balt	permit. Page Department Important: I any injury o		21. Signature of Formal Pervice License 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD PIKESVILLE, N											-			
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A consequence of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										Approximate Interval Between Onset and Death 3 acys						
00	executed ian and urial-transit	lical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												
. Box 68760	Attending Physician: The law requires that the death certificate be streamed. After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the but	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic predictions on the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 5 Other (speed of the pregnant at time of the pregnant at													delivery Day Year		
ls, P.O.	law requires that thas thas been signed by a should be deta		Part II. Other significant of		_										e to the cause of death? Probably 4 □ Unknown		
Division of Vital Records,	The law requate has been page 2 shou	Completed by	Hypertension,	Metabolis	Acidos	is Re	val Fai	lure				24a. Was auto perf 1 Yes	opsy ormed?	prior deat	e autopsy findings available to completion of cause of h? Yes 2 No		
Vital	ysician: The s certificate director, pag	To Be	25. Was case referred to me examiner? 1 Yes 2 No		pital:	patient 2 🗆	ER/Outpatier	nt 3 🗆 🗆	Othe	ace of Dea er: 4 □ Nu	-	******	idence	6 ☐ Other (S	pecify)		
on of	nding Ph ath. r: After thi ie funeral	Certificate: 7		Pending nvestigation	28a. Date of		28b. Time of injury		28c. Injun work	y at	2	8d. Describe					
Divisi	To the Hospital or Attending Physician: Within 24 hours after deactoreath: To the Funeral Director After this certific completed filled in by the funeral director,			Could not be letermined	28e. Place of building	f Injury - At ho , etc. (Spec <i>ify</i>	me, farm, stro)	et, facto	ry, office		2	28f. Location (City or To			Rural Route Number,		
	the Hospi nin 24 hou the Funer	Medical	(Check 2 Med only one) 3 Cer	tifying Nurse P	On the basis	of examination	and/or invest	tigation, ir	n my opinio	on, death o	ccurred at	the time, date	and plac	e, and due to t	the cause(s) and manner states		
	To To O		29b. Signature and title of c	ertifier Bvv) M	10, PhD		29	lc. License	e number ES O	00		_		onth, Day, Year)		
			30. Name and address of p	erson who comp	pleted cause	of death (Item	23a) (Type, F	rint)			_	more			,		
	Sta Registra		31. Date filed (Month, Day,	erson who complete who vives for the complete co	32 Reg	gistrar's Signat	1. 4	ale									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Physician 0 < T 2010 /Medical County of Death 4b. City, Town, or Location of Death 4c. 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE BALTIMD 21208 ENVOY-PIKESVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 212-03-0930 3-15-1917 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 1 ☐ Yes 2 No RANDALLSTOWN Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 21133 U.S.A. 3 CEDAR HILL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify. Specify: WHITE δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE COUNTY filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS CAFETERIA CASHIER 12 permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If Item 27 is marked other i any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MINNIE (SCHWARZ) JOHN STADELMEIER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RANDALLSTWON, MD 21133 GAIL WEBER/DAUGHTER 3 CEDAR HILL ROAD Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE CEMETERY 10-5-10 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD S Ce Licensee 22. Name and Address of FacilityCVACH / ROSEDALE FUNERAL HOME 21. Signatur 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1ea V5 disease or condition resulting in death) Vernentia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1∐ Yes 1 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 1 🔲 Inpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar

DHMH 17 Rev 1/2001

ate 31. Date filed (Month, Day, Year)

670 (N Che r 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V Charles St, Suite 4105, Touson MD21204

B. Jane

D0061199

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept 19, Physician/ 2010 10:00A M Janet Derr Bland Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12117 Wheeling Ave Upper Marlboro Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) Mar 7, 1920 1 - M 2 XXF Months Hours Min 238-20-4967 90 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director MD Prince Georges Upper Marlboro 1 Yes 2 XXNo 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a 12117 Wheeling Ave 20772 items 2 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Force Black, White, etc. ò ģ 1 Never Married 2 Married 2**X** No Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 XXNo Specify: Specify: Black "natural", 3 XX Widowed 4 □ Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hair Stylist Hair Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Derr Bessie Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is 12117 Wheeling Ave., Upper Marlboro, MD Yolanda Parris 20772 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date cemetery, crematory or other place)
Oaklawn Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Bernoval from State ò Sept 27, 2010 Charlotte, NC injury o 4 ☐ Donetion 5 ☐ Other (Specify)) Tile of Funeral Nelvite Licer 22. Name and Address of Facility
Fink Funeral Home, P.A. Gregory Glen Burnie, MD 21061 Enter the diseas or heart failure 23a. Part plications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Intervai Betweer shoc Immediate Gause (Final disease or condition resulting in death) Onset and Death Physician/ SOIGT 7158VB spread Phi mac westers Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any leading to instance Examine if any leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABRIKS Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No , MYSEMIPIE EMIA 24a, Was an autopsy Physician: The within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Presidence} \) 6 \(\text{Other} \) Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar SV1/ 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra's Signa

106 INVING STAGET.

31. Date filed (Month, Day, Year) OCT 0 6 2010

mB 036400

20070

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month SEP. ^{Day} 2010 BARBARA GAIL BORDEAUX BONAPARTE 24 9:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HAVRE de GRACE HARFORD MEMORIAL HOSPITAL HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEP. 1, 195 Birthplace (State or Foreign Country) Funeral 1 □ M 2XX F Months Days Director 201.46.7966 55 Yrs Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified 28a-f tXX Yes 2 ☐ No MONTGOMERY MONTGOMERY VILLAGE 10e, Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 20016 SPUR HILL DR. 20886 LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Yes 2 XNo ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XX No Specify: If Yes, Give **BLACK** 3 Widowed 4 XXDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 5 PROGRAM SPECIALIST U.S. ARMY DEPT. OF LOGISTICS of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOE BORDEAUX, JR. WILLIE MAE HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES M. BONAPARTE 20016 SPUR HILL DR., MONTGOMERY VILLAGE, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 XX Removal from State 5 Other (Specify) PINE CREEK BAPT. CEM OCT. 2, 2010 BURGAW, NC of Funeral Service License 22 Name and Address of Facility P.A. 21. Signatut GREGORY F\I∏K M01148 426 CRAIN HWY.S., GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or here, failure. List inly ne cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ DUDDEN Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE been signed by the attending should be detached for use. 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day 9 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Morbid Obesity; Hypercholesterolemia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Insulin Dependent Diabetes Mellitus; Obstructive 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? ADNEA Sleep Aprica
25. Was cas referre to medical 1 Yes 2 No Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) the Hospital or Attending Natural 5 \square Pending Division Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🔲 Certifying Nurse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Zerti 8 of person who completed cause of death (Item 23a) (Type, Print) 201 McKeNNA . Date fled (Month, Day, Year) 32. Registrar's Signature State OCT 0 6 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland Department of Health and Wental Hygiene State of Maryland Department of Health and Wental Hygiene Phys Registrar

1 - State amend item 5 per fh g908 10-13-10 vt
Registrar

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Blown useph Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maris Baltinove Stella 52Spcial Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 40-9048 67 Months Hours Min Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Ellamont 21216 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Black Year or Dates. any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10+4 aintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2010 E/SIe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Daughta Mahan 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Date OCTOBER 1💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 1101 E. North Ave March heneal Home East 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L • o me runeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 KM Probably 4 ☐ Unknown JOSEPH BLOUNT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) ٥ 201 person who completed cause of death (Item 23a) (Type, Print) **JACKIE** JONES 2300 DULANEY VALLEY RD. TIMONIUM. MD 21093 32. Registrar's Signature State Registrar Jan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 30^{Bay} 2010 Physician/ Sept. John Watson Barton, Jr. 9:02A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Ctr. Baltimore City 8. Date of Birth Oct. 19,1961 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 🛛 M 2 🗆 F Months Hours Maryland 214-88-5809 48 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Dundalk Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21222 1973 Haselmere Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1

✓ Yes 2 □ No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Instructor Trucking Industry 12 Years Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Malden Surname) ဂ Rhea M. Hibner John W. Barton, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1973 Haselmere Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary L Barton (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gdns 10/4/2010 20a. Method of Disposition 20c. Location - City or Town, State 1¾ Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Bidame Rud Are Fufferal Home of Dundalk, Inc. Dundalk, 7922 Wise Ave. Mart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY BOL Medical resulting in death) Due to (or as a consequence of) Examiner See that distily list over this is Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 🗍 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed OBESI Yes 2 XN 1 Yes 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗐 🗸 🗸 0 မ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 3340 .000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WISE EPAI 31. Date filed (Month, Day, Year) 32. Reg State Barke

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (Physician/ Joann Bailey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Good Samaritan Baltimore n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Sept. 26, 1946 Months Country)
MD Director 64 213-42-2351 Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3600 Chesterfield Ave. 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceud.
Armed Forces?
1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 XNever Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify:Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+)
4 vrs Elementary/Seconday (0-12) Para-Professional Baltimore City Sch. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Pinkett Lucille Sr. 19a. Informant's Name/Relationship (Type, Print)
Javonica Powell/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5618 Sagra Rd. Balto, Md 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, onation 5 Other (Specify) King Memorial Pk. Oct.11,2010 Balto, Md. 22. Name and Address of Facility
alvin B. Scruggs Funeral Home
412 E. Preston St. Balto, Md. ature of Funeral Service Licensee 141 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ordid 1 disease or condition resulting in death) mi 0 C Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 4 Pregnant Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hears Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform seate (0,000 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No Hospital: 1 Yes 욘 1 Inpatient 2 R/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Testifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) yricia 4005940 2010 october 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registra s Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 3 Day 2010 Year SIBYL JACKSON BROWN 2:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 102 Brightwood Club Drive Baltimore County Lutherville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 😾 F Months Days Hours July 29 Year 1914 Maryland Director 214-03-0352 96 Usual Residence of Decedent 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕅 No Maryland | Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 102 Brightwood Club Drive 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Congreve Jackson Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sibyl B. Gibbs (Daughter) 2200 Wiltonwood Road, Stevenson, Maryland 21153 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 10/11/2010 Pikesville, Maryland 21. Signatura of Funeral Survice Langue TCHELL-WIEDEFELD FUNERAL DO York Road, Baltimore, Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of; burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No

9 Unknown Month Pregnant at time of death sate has been signed by the page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renewal and Alwesox locatee Carwascular Deace. 23e. Did tobacco use contribute to the cause of death? Completed by Alberoschesotie Cardiovascular 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Certificate: To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e and title of certifie 29c. License number 2010 D. 630 N Charles St., Ste 5, Bouttimore, MD W. Iglehout, 32. Registrar's Sgnature

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State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 11 58 AM 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Baltimore Raven och If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day.) April 17 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2XXF 213-28-5561 Days Hours Min. 79 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Baltimore County Baltimore Maryland 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9900 Walther Blvd. Apt. # 306 21234 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes ¾ No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes XX No Specify. "natural", 3√ Widowed 4 □ Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Baltimore County 10th grade (0-12) Callege (1-4 or 5+) Public Schools Cafeteria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ George W. Nelson Anna H. Daille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Clark (Son) Forest Hill, Md. 21050 2232 Ady Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Pk.:10-6-2010 Baltimore, Md. 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Lassahn Funeral Home <u>7401 Belair Rd. Baltimore,</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 menths?
1 Yes 2 No Pregnant at time of death Month been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s has autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending s after death.

I Director: Aft
d in by the fur Accident Investigation 1 Yes 2 No 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

only one) 29b. Signature and

31. Date filed (Month, Day, Year,

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DHMH 17 Rev 7/2009

32. Registrar's

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

22

29d. Date signed/(Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1955 2010 10:55 AM inna actober Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A OHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2XX Days June 13,1938 Months Hours Min Director 217-34-6573 72 Yrs. Mary land Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 955 Dalton Avenue 21224 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Earnest McClaskey Elsie Mae Herman 19a. Informant's Name/Relationship (Type, Print) (Daughter)
Mrs. Patricia L. Balzano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Road Apt. 3 Dundalk, MD 21222 Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery Date 20c. Location - City or Town, State 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/5/2010 Baltimore, Maryland Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ neu moma Medical resulting in death) Due to (or as a consequence of) **Examiner** structive Pulmonar NYOWA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed MOX sician and burial-trans Due to (or as a consequent of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Use Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1XInpatient 2 🗌 ER/Outpatient 3 🗌 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1.X Natural 5 Pending work?
1 Yes within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2010 RES- 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State Registrar	State of W	ai y lai le		tificate			ind mor		Reg. No.	010		3	88
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Baltimore, Maryland 21215-0036	and N		19a. Informant's Name/Relations				ng Address (Code)	
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. BC	e atte	icia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown										Month Day Year			
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Div	s after	Sert	4 Homicide	building, e	etc." (Specify	<i>'</i>)					City or To	own, State))			
Div To the Hospitel or	hours unaral	edical (29a. Certifier 1 Certifyir	ng Physician: To the bes Examiner: On the basis	at of my know	wledge, deat	h occurred a	it the time	e, date an	d place, and	d due to the	e cause(s)) and manr d place, an	ner as si	tated.	e(s)
tha H	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medi	one) 29b. Signature and title of certifie	and manner s				License					ite signed (
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AMEND ITEM#95erFH, G908, 10/6/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 8:10 AM OCTOBER Audrey Μ. Crouse 2010 Medical Oi 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death ST AGNES HOSPITAL BALTIMORE 8. Date of Birth June , 7 , 1956 9. Birthplace (State or Foreign Country) LIC (5. Social Security Number Funeral 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Days 1 □ M 2 🖔 F Hours Months Director Vrs 215-70-1122 54 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Baltimore City MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1305 Inverness 21230 USA Ave. death v 12. Was Decedent Ever in U.S. Armed Forces?
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If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 72 hours after Specify: white 1 ☐ Yes 2XX No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Howard County Elementary/Seconday (0-12) College (1-4 or 5+) Transportation School Bus Driver other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Melvin T. Baldwin Estelle S. Homens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Inverness Ave. Baltimore, Maryland John J. Crouse-Husband 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Dunial 2X Cremation 3 Removal from State any injury or Atlantic Crematory Oct.7,2010 Glen Burnie MD 4 ☐ Donation. 5 ☐ Other (Specify) Signature of Funeral Service Likense 22. Name and Address of Facility Ambrose Funeral Home Inc. 328 Sulphur Spring Road Arbutus MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA ₽πysiciaπ/ TOST OBSTRUCTIVE disease or condition resulting in death) 1 DAY Medical Due to (or as a consequence of): Examiner CANCER METASTATIC LUNG YEARS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant 9 Unknown 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 2 9 Unknown cate has been signed by the a page 2 should be detached Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၀ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury death. Accident
Suicide 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - 10 - Thy MEDICAL DOCTOR D0069370 OCTOBER 01 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 KwmmE NTIM 900 CATON ANE BALTIMORE MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's signatur State OCT 0 6 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 03, 2010 8:25 AM ARNOLD BENNETT CUSHING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral 1 🗖 M 2 🗆 F Months Days Hours Min. Country) 09976971952 MA 58 019-44-2234 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Completed by Funeral Director Examiner must be notified 1 🏋 Yes 2 □ No BALTIMORE N/A MD 10 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a 21215 USA 6801 WESTERN RUN DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ō 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) the COMPUTERS 5+ SOFTWARE ENGINEER Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) h and Mental h ပ္ MITTELL CUSHING MIRIAM NORMAN other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a DIANE SIPPLE-CUSHING/WIFE 6801 WESTERN RUN DRIVE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State SERVICE CORP.: 10/06/2010 TOWSON, MD 4 Donation 5 Other (Specify) HILLTOP Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ Parkinson's Diseast veurs disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 YNo Month Pregnant at time of death g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 **N**No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Tes 2 🗌 No Accident Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

(Check only one)

29b. Signature and title of certifie

leura Pate 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore

29c. License number D0070635 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9/30/2018 ay Physician/ 1:52 A Doolev Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Halethorpe 1245 Circle Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours 11/09/1912 1 🗆 M 2 🗓 Director Maryland 215-18-1889 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County within 72 hours after death with the Maryland Director Baltimore Halethorpe 1 Yes 2X No MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21227 United States 1245 Circle Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Never Married 2 Married Yes 212 No Completed by Specify: White Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced "natural", Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than " College (1-4 or 5+) the Administration Secretary 18. Mother's Name (First, Middle, Maiden Surname) filed 17. Father's Name (First, Middle, Last) Ella Farrell John C. DeBoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Oakland Court, Halethorpe, Maryland 21227 Michael J. Dooley (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or New Cathedral Ceme. 10/4/2010 Baltimore, Maryland Onation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. re of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician MINUTES disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the as 1 IE FEMALE: yes, outcome of pregnancy nse 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month for 5 Other (specify) Pregnant at time of death n signed by the a 9 Unknown P.O. I Part II. **Other significant conditions** contributing to death b<u>ut</u> not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? deGENERATION 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 29c. License numbe 29b. Signature and title of certi 6200

State Registrar

DHMH 17 Rev 7/2009

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Physic	cian/		1. Decedent's Name (First, Middle	le, Last)					2. Date of Death Month OCTOBE	Day	2010	3. Time of Death			
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Funera Directo	_		5. Social Security Number 213-37-2280	6. Sex 1 🕅 M 2 □ F	7. Age (ln)	75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 02/25/1	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fo. Country) KIEV					
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To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Mod		29b. Signature and title of certification	er /		30. Name and address person who completed cause of death (Item 23a) (Type, Print) MOHIT NARAWS.: 5555 CENTER ST WEST MWITE.; MD									
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To the Hosp within 24 hc To the Fune completed	Mod		30. Name and address of person	n who completed cause	se of death	(Item 23a) (Type,	Print) CENTER	57 400 St W	EST MWS	10/3	[201 D Q11	15.7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NANCY MARIE FORD 10:15 AM October 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington BUTNIC DA/Timore MeLical Center Gken Anne Arande Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖈 F Maryland Months Month, Day, Yea July 31 Days Hours Min. 220-40-5303 **Director** 69 ,1941 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exam<u>iner must be notified at</u> 10a. State 10h Count and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel 1 Yes 2 No Glen Burnie 10f. Zip Code 10g. Citizen of What Country? Funeral 7226 Crown Road 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Unkown William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie M. Salatto (Friend) 143 Dunlap Road, Pasadena, Maryland item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10-04-10 | Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem. 21. Signature of Function Service License 22. Name and Address of Facility McCully-Polyniak F.H. and Road, Pasadena, Maryland Mountain art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between formediate Cause (Final disease or condition Onset and Death Physician OBSTRUCTURE Chronie LAMES Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consquence of Cause (Disease or iinjury that initiated events that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
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5 Other (specify) for in the past 12 months? Month Year Pregnant at time of death 9 Unknown g 🗌 Unknown has been signed by le 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 this certificate within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo I⊠ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
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DHMH 17 Rev 7/2009

Physician /Medical Examiner

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To the Hospital within 24 hours a To the Funeral L Hospital

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P.O. Box 68760,

Division of Vital Records,

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

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Baltimore.

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experiment at the redified at

Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated event resulting in death) Last Physician/Medical

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tohacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an

autopsy performed? 1 ☐ Yes

2 WNo

27. Manner of Death 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

28c. Injury at Work? 1 ☐ Yes Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie

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29b. Signature and title of certifier

29c. License number

2 🗌 No

29d. Date signed (Month, Day, Year)

30. Name and address of prson who completed cause of death (Item 23a) (Type, Print)

Manai Chardon U17 Stemmers Runld,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ ONA Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Northwest Hospital Seasons Hospice 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Hours Min Maryland 88 **Director** 213-28-3810 Usual Residence of Decedent 28a-f shov 10b County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c, City, Town or Location Examiner must be notified at Director Anne Arundel Brooklyn 1 ☐ Yes 2X No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 251 West Meadow Road 21225 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify Completed 3 XWidowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Herold George Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles D. Fessenden (Son) 251 West Meadow Road, Brooklyn, Maryland 21225 other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Department o Important: If any injury or ō Meadowridge Memorial 10/07/2010 Elkridge, Maryland ☐ Bonation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility Signatu Hubbard Funeral Home, Inc. ne, Baltimore, Maryland 21229 4107 Wilkens Avenue, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Jach line. Onset and Death Immediate Cause (Final Physician/ disease or condition Deumoni Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perforn death? 2 🗆 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: မ 1 U Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 No 2 Accident
3 Suicide after death Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of persoi who completed cause of death (Item 23a) (Type, Print) 10000 filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death VIOLA Physician/ ANN GENUARDI OCTOBER 2010 11:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death
BALTIMORE **Examiner** GILCHRIST HOSPICE CENTER TOWSON 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 83 Days 12-13-1926 NEW YORK Director 119-20-2479 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1805 WEYBURN ROAD 21237 U.S.A. 11, Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced Specify: WHITE Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN Т. FINNERTY VIOLA E. (COWPER) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 1805 WE ANTHONY GENUARDI/SON WEYBURN ROAD ROSEDALE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 10-6-10 BALTIMORE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Acuterenal Medical resulting in death) Due to (or as a consequence of): **Examiner** SEPSI'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed unhan Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year 1 Yes 2 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia, cardiomyopathu 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? insofficience 24a. Was an performed? Yes 2 Day 2 🗌 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 M No Hospital: Other: ျပ 4 Nursing Home 5 Residence 6 Cother (Specify) Hospi'c 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Praction of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

ate

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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charles

00070635

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October Clyde Garnes 2010 5;55 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Randallstown <u>Season's Hospice</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Months Hours Min. Day, Year) 1 □**X**M 2 □ F Director MD 89 20-03-4275 ortant. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Owings Mills 1 Yes 2 No Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21117 U.S.A. 9266 Charisto 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: Black 3√☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th grade (0-12) College (1-4 or 5+) **2yrs** Postal Service Mail Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clyde C. Garnes Ruth Wicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9266 Charisto Ct., Owings Mills, Md 21117 Nena Maddox-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) On-Site 10/5/2010 Baltimore, Md 21. San ture of Funeral Service Ucensee March F/H West Vine 21215 4300 Wabash Ave, Baltimore, 23a. Part/l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shortly, or heart failure. List only one cause on each line. Interval Between Eng. Stage Alzheimers Dementia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year n signed by the a ld be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 performed?/ Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 🗀 Pending 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Carthying Nurse Fractioner: To the coast of my local state of the cause of the caus (Check within 2 To the F unity ional 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) > Mskajapaksem D 10/2/10 DUUS7-465

Registrar

State

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5-703, Baltimore, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N · S · Rajapa LSE · M · D 2835 5 m · M · A v -

32. Registrar's rignatur

N.S. Rajapakse, M.D

31. Date filed (Month, Day, Year)

OCT 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Charles Gresham Physician/ Month October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Harford 4b. City, Town, or Location of Death **Examiner** Upper Cheasapeake Hospital Bel Air Social Security Number 143-03-4380 If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months 1 🛛 M 2 🗆 F Davs Hours Min. 8/16/1917 Director 93 I Isual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Completed by Funeral Director Harford Abingdon MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3639 Woodsdale Road, Apt. H 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒No Black, White, etc. 1 Never Married 2 Married 72 hours after Black 1 Yes 2 No Specify: If Yes, Give 3 ₺ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Crossman Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Hazel Gresham Ora Waller 19a. Informant's Name/Relationship (Type, Print)
Melinda Ann Gresham/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 2 3639 Woodsdale Rd., Apt. H, Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 110/5/2010 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Serv
PO Box 1413, Baltimore, 21. Signature of Funeral Servine Licensee Dorota Marshall Services more, MD Marinal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ev disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician. The law requires that the death or within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the Attention. in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 9 Unknown be detached 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 25. Was case referred to medical examiner? **Division of Vital** completed filled in by the funeral director, Be 26. Place of Death (Check only one) 24 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မြ Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 060768 chesa peake D., Uffer Chesage, Bel Air, MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Juhanna

skhada

500 Upper

10-07469 Shirley Ann Gray Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 31200

		1- For State Certificate of Death Reg. No.											
Physici Medical Exam			h										
3		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 70 S. Church Street Westminster Carroll											
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or											
Director		220-40-7807 1 M 2 F 67 Yrs. Months Days Hours Min. 5-27-1943 Foreign Country) MD											
any		Usual Residence of Decedent 10a. State	Limits										
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ant of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 70 S. Church St., Apt. 10 10f. Zip Code 10g. Citizen of What Country? USA											
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) Carroll G. Cool Sr. 18. Mother's Name (First, Middle, Maiden Surname) Mary Shatzer											
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e, MD 1 and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State											
Baltimore, permit. Pages 1 ar Department of Hee important: If ite		1 \(\)\(\)\(\)\(\)\(\)\(\)\(\)\(D										
Baltimo permit. Page Department Important: injury or otd	ij	21. Signature of Funeral Service Licensee 122. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157											
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Ir Between Onse											
/Medical Examiner	Western Atheres I and a Continuous I and a Continuo												
	_	Sequentially list conditions, b											
	Examiner	if any, leading to Immediate Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): C. C.											
ecuted and - transit		events resulting in death) Last Due to (or as a consequence of): d.											
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	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Yea	ır										
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i of Vital Records, P.O. E ing Physician: The law requires that the d After this certificate has been signed by the bineral director, page 2 should be detached	ð	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 V Unkn											
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Reco The law cate has	dmo	performed? death?	No										
ital Rec nician: The s certificate irector, page	å	25. Was case referred to medical examiner? 1 Vec 3 No. Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other. Scene	=										
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the functal director, page 2 should be	ا: <u>٦</u>	27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	-										
Sior Attend death. ector: by the	ertification	Accident Investigation 1 Yes 2 No	-										
Divi	ertifi	3 Suicide 6 Could not be determined Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or Town, State)	, City										
Hos 24 h Fun tely	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
To the within To the comple	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	\dashv										
		Carol Hallan O.C.M.E. September 29, 2010											
Show &		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
		31. Date filed (Month, Day, Year) OCT 0 6 2010 Assert B. Sparks											
	-	The state of the s											

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene												
			Registrar	Cer	tificate of De	ath		eg. No. 2	0 3/20/			
	Physicia		1. Decedent's Name (First, Middle, Last) Murianna Gubenko				2. Date of Deat Month October					
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ncation of Death	OCTOBER	4c. County of Death				
	LXamiii	CI	SEASONS HOSPICE @ NORTHWEST	HOSPITAL	RANDALLS			BALTIM				
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year If Months Days H	Under 24 Hrs.	8. Date of Birth	Year) 9. E	Birthplace (State or Foreign			
-	Director		212-49-6678	91 Yrs.			07/03/1	919	Country) UKRAINE			
	and show	١٥	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits			
	Maryl 28a-f otifie	Director	MD BALTIMORE	OWINGS N	MILLS				1 ☐ Yes 2 🕅 No			
	h the	a D	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?			
	ith with ms 2% must	Funeral	3410 ASSOCIATED WAY, #408	110 140	21117				USA			
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Maryland	d be f Menta arked atic ev	은	ZALMAN	LEWINSI	KY	SOFYA		OL	CHOVA			
/ar	shoul and l		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and							
	and 2 Health em 2: ther t		NELLI GUBENKO / DAUGHTER 20a. Method of Disposition	3410					LS, MD 21117			
nor	age 1 ent of ht: If it y or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, cren	natory`or other place)		i	20c. Location - City				
Baltimore,	permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.		21. Signalure of Funeral Service Licensee		RE HEBREW . Name and Address o		5/2010 L LEVINS	BALTIMOR ON & BROS				
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5	pital o		29a. Certifier 1 Vertifying Physician: To the best of m			<u> </u>						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of monly one) 1 Vertifying Physician: To the best of monly one 2 Medical Examiner: On the basis of examiner: To the basis of examiner: On the basis of examiner: O	amination and/or investi	igation, in my opinion, d	death occurred at	the time, date and	d place, and due to the	e cause(s) and manner stated.			
	To th To th	_	29b. Signature and title of certifier	, , , , , , , , , , , , , , , , , , ,	29c. License nur	mber		9d. Date signed (Mor	nth. Dav. Year)			
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			30. Name and address of person who completed cause of dei N · S · Rajapa KSE, M · D 2835 S	ath (Item 23a) (Type, Pi 5 m i TH AV -	rint) S-203, E	Baltimo	M. MD.	21200	ì			
	Stat Registra		31. Date filed (Month, Day, Year) 32. Fegistrar 0CT 0 6 2010 32. Fegistrar	's Signature	ake			-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 2 Day 2010 Year 205 P Emory Lee Huber, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford 200 Kings Crossing Circle Apt. Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 1 ⚠ M 2 ☐ F 9. Birthplace (State or Foreign **Funeral** Days Now 19 , Yel 930 Maryland 79 **Director** 213-28-1210 Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 200 Kings Crossing Circle Apt. 12. Was Decedent Ever in U.S. Armed Forces?
1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Community College data processing supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Edna Hutton Emory Lee Huber, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Kings Crossing Circle Apt. 2D Bel Air, MD 21014 Merlene C. Huber / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 \square Burial 2 X Cremation 3 \square Removal from State 10/4/2010 Baltimore Bayview Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ten years disease or condition resulting in death) Meningioma Medical Due to (or as a consequency of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Whenown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 20 No 2 🖣 No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 M Residence 6 \square Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical 1 M Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 355 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel AIR MARYLAN MARK ORTH AVENUE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ROLF HATLEBERG 6:40 A Medical October | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Morningside House of Friendship Hanover Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗙 M 2 🗆 F Months Days Hours Min June 29, Year) Norway Director 529-60-2759 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie 1 Yes 2 X No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Hammarlee Road 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Š 1 X Never Married 2 Married ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Plant Caretaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Blattmann Ole M. Hatleberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Hammarlee Rd., Glen Burnie, Maryland Adrienne Roper (Friend) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory, LLC 10/4/2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E Ecker 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if a y, leading to immedicause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Dav Year Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed 2 🗶 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 A Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred iniury 1 🚇 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after deatl the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 1<mark>④ Certifying Physiciam. To the b</mark>est of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type 30. Nam e and address of person who 31. Date filed (Month) State

DHMH 17 Rev 7/2009

Registrar

OCT 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 00 **Physician** 2011 /Medical Examiner If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) uly 9,1921 9. Birthplace (State or Foreign 7. Age **Funeral** Pennsylvania Days 1 M 2 D 89 July Director 207-07-2668 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 □Yes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 4 Senate Drive 21122 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🛣 No Specify ģ Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Lewis Siperko ပ Margaret Gwynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shc Department of Health and Important: If Item 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type. Print) 979 Shoreland Drive Glen Burnie, Maryland 21060 Dennis A. Huffman (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/08/2010 Glen Burnie, Maryland Glen Haven Mem. Pk. 21. Signature of Fune al Service Licensee 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician disease or condition resulting in death) or as a consequ /Medical The Heart Guillive Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 He
9 Unknown Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sign 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page Physician: The 2 No Vital 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 24 hours after deat Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

State

31. Date filed (Month, Day,

6 2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month <u>Gilbert Joseph Hartlieb</u> AM M 10 2010 3:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stell<u>a Maris Hospice</u> Timonium Baltimore If Under 24 Hrs. Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Hours Director 215-03-4741 93 04/04/1917 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4223 Chapel Road Apt. S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 🔊 Yes 2 🗆 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married OCTOBER 5, 2010 3:15 a.m. Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Year or Dates. WW II White or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Accounting Manager Bethlehem Steel Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Hartlieb Genevieve Hughes Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 191 714189 Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Kunkel 18 Silver Spruce Terrace - Kingsville, MD (PR) 21087 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Joseph Church Cem. 10/11/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses 6 11750 Belair Road - Kingsville, Maryland 21087 as 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, disease or condition CARDIOMYOPATHY Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease of it that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 **X** No 2 🗌 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 X No Other: မြ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certife 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State OCT 0 6 2010 Registrar

GILBERT HARTLIEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	of Maryland	•	tment of Heal <i>ificate of Dea</i>			71	110	31206		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cert	meate of Dea		2. Date of Dea			3. Time of Death		
	Physicia Medic		Agnes A	nita	Ho1r	nes		Oct.	2 2010 3:45 A M				
	Examin		4a. Facility Name (if not institution, give street and no Gilchrist Nursing Cen	mber) ter		4c. County of Death Towson 4c. County of Death Baltimore Co.							
*	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	Towson If Under 1 Year If U	g. Birthp	place (State or Foreign					
	Director		216-20-1065 1 □ M 2 🔀 F	84	Yrs.	Months Days Ho	ours Min.	Count Mar	yland				
7	how at	ŗ	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	ition				1	0d. Inside City Limits		
	Ba-fs	Director	MD Baltimore			Nottingha	am				1 ☐ Yes 2 🏻 No		
-	a or 2	il Dir	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	itry?		
1	ms 23	Funeral	3809 Crestvale Terr	ace	112 W		1236	oify Yes or No-		ed Sta			
	1 and 2 should be filed within 72 hours after dearth with the maryland. If Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	Armed	Forces? s 2 🔀 No iive	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.								
5	"natur	plete	15. Decedent's Education (Specify only highest grade complete		(Give ki	nt's Usual Occupation nd of work done during	g most of worki	ng I	16b. Kind of	Business Ind			
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2	Iled work Hygis other vent, t	å	17. Father's Name (First, Middle, Last)			18.	Mother's Name	(First, Middle,	Maiden Surnai	ne)			
70	Menta Menta larked atic e	မ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,										
<u> </u>	th and I		19a. Informant's Name/Relationship (<i>Type, Print)</i> Susan Shea (Daug	hter)	-	Address (Street and N Crestvale			r, City or Town, : ingham		Code) 21236		
- ,	I and if Heal item 2		20a. Method of Disposition		ce of Dispos	ition (Name of atory or other place)	1	Date	20c. Location		own, State		
2 ,	Fage 1 ment of ant: If it ury or o		1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	iii State		Cemetery	10/5	/2010	Ba1t	imore,	Maryland		
	permit. Page 1 and Department of Heali Important: If item 2 any injury or other once.		21. Signature uneral Service Licens e		ੂੰ 179	Name and Address of Ida-Ruck fu 22 Wise Ave	Facility ineral l e. Dun	Home of dalk Ma	Dundal ryland	lk, In 21222	c.		
			23a. Part 1. Enter the disease, or complications the shock, or hear failure. List only one cause on	each line.				r respiratory arr	rest,		Approximate Interval Between Onset and Death		
·P	nysician/ Medical	W	Immediate Cause (Final disease or condition resulting in death)	o (or as a conseque		fraltive	2			1	Onsor and Doam		
-	Examiner		I ←	o (or as a consequen	nice on.			,	2. 2	53			
-	- +	iner	Sequentially list conditions, b. Due cause. Enter Underlying	o or as a conse ue	nce of:				2/-9	0,			
1	and -transi	Examiner	Cause (Disease or iinjury	o (or as a conseque	nce of):				1	700			
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00/0	nicate ng phy as the	Medi	IF FEMALE:					XX	a				
DOX DO	requires that the death befullo been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	outcome of pregnand re Birth 2 Fetal of egnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)			23d. [Date of delive Month	ery Day Year		
<u> </u>	y the a	hysic	1 Yes 2 Sto g U		aui J	Other (apecity)		12					
5	inat t	by P	Part II. Other significant conditions contributing to	death but not resul	ting in the ur	derlying cause given in	n Part I.		1.7		ne cause of death?		
ds,	equire: een sig nould k	eted	Dementia		-			1 🗆			bably 4 Unknown psy findings available		
Records,	In the hospital or Attending Prysician: The law requires that the death behind with 24 hours after death. Within 24 hourst Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Completed						autor perfo			mpletion of cause of		
NICALI	sician: certifi irector,	Be C	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital:	 ☐ Inpatient 2 ☐ E	TD/Outpations	- Other:	of Death (Check	only one) me 5 ☐ Resid		thar (Spacifi	the spice		
5	g rnys er this neral d	te: To	27. Manner of Death 28a. Da		28b. Time of injury	28c. Injury at work?		28d. Describe h					
	fendin leath. or: Aft the fur	Certificate:	2 Naccident Investigation Sept	Mber 24,2010 1	unknow	VM 1 ☐ Yes		acciden					
DIVISION	al or Ar s after c l Direct d in by	1	4 Homicide determined bu	ce of Injury - At hom Iding, etc. (Spec <i>ify</i>)	1			28f. Location (S City or Tow	otreet and Nun yn, State) EQ	Stern Stern 2122	Rouse Number, Augase		
	Io the hospital or Attending Priysician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Medical	29a. Certifier 1 Sertifying Physician: To the (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	e best of my knowled	dge, d eath o and/or investi	ccured at the time, date gation, in my opinion, de	eath occurred at	the time, date a	and place, and	due to the ca	use(s) and manner stated.		
	vithir To th comp		29b. Signature and title of certifier) , ,		29c. License nun	-		29d. Date sign	ned (Month,	Day, Year)		
			30. Name and address of person who completed c	ause of death (Item 2	23a) (Type, P	dent/	7063		10/2	110			
			101000 Putel 670	1 N (6	IUME	c St. 1	Balti	more	MO	212	24		
	Sta	te	31. Date filed (Month, Day, Year) 32	Registrar's Signatu	e bar	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ^{Day} 20 10 Physician/ SEPTEMBER MIKHAIL **IND ENBAUM** 7:04 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6705 LAURELWOOD AVENUE **BALT IMORE BALTIMORE** 6. Sex 1**XX**M 2 □ F Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 07/06/1955 55 214-33-7169 Director RUSSTA Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No **BALTIMORE** BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6705 LAURELWOOD AVENUE 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. WHITE Specify: 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER COMMERCIAL TRUCKING of Health and Mental Hygier fitem 27 is marked other trother trother traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ INDENBAUM SIMA GOREVICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SVETLANA INDENBAUM/WIFE 6705 LAURELWOOD AVENUE. BALTIMORE, MD 21209 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM. 10/03/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 9900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Estert Placement 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician; The I
 24 hours after death.
 Funeral Director: After this certificate h 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

**Manne Smooth CRUP 29c. License number 29d. Date signed (Month, Day, Year) R112789

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person with completed causing the truth of the completed causing the truth of the completed causing the truth of the completed causing the causing the completed causing the completed causing the completed causing the completed causing the causing the completed causing the cau

Amend #17, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0 2 10:30am Physician/ Ruth A. Kemp 10 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Manor Care If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1/2/24 Days Min. 1 M 2 X F Months Hours 226-30-7328 **Director** VA Usual Residence of Decedent 10b. County N/A or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at Funeral Director MD Baltimore 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21213 3646 Raymonn Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Spec frican Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced Completed Amer. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Cert. Nursing Ass't Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Thompson unk Emma Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3646 Raymoon Ave, Balt.,MD 21213 Ruth A. Kemp/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Arlington Nat'l Burial 2 Cremation 3 Removal from State Arlinton, VA 11/22/10 4 Donation 5 ☐ Other (Specify)-^{22. Name and Address of Facility}Hari P. Close F.Svs,PA 5126 Belair Rd,Balt.,MD 21206-5105 21. Signature of Funeral Service Lipensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial. Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached it 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No Certificate: To 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manuar of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending M Accident Investigation completed filled in by the 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year, lathan Woods Load MD 21234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 0 6 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of Ma	aryland		artment of H		and Me	ntal Hy	giene				
			Registrar 1. Decedent's Name (First, M	liddle I as	<i>t</i>) .		Cer	tificate of L	Death	T 2	. Date of Dea	Reg. No	010	31209		
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+	Medic Examir		4a. Facility Name (if not instit	tion, give	street and number)		_	4b City, Town, o	r Location o			4c. County of Death				
-	/ 		7530 Westy	18/1	. Ka		- 4 C :- 41 4 A	DALLAY If Under 1 Year	one	HU	11220		BAltimore			
	Funeral Director		5. Social Security Number 220–18–9231) 6. Se	ØM2□E	e (in yrs. ia: 34	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	. Date of Birt (Month, Day 01 / 1 7 /	n , Ye <i>ar</i>) 1926	9. Bii Co Ma	rthplace (State or Foreign ountry) ryland		
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	n with	Funeral	7530 Westfi	eld R	d.			21222				Ţ	USA			
	r deatl r iter iner n		11. Marital Status 1 □ Never Married 2 ☒	Mauriad	12. Was Decedent E Armed Forces?			Vas Decedent of H Yes, specify Cuba	ispanic Oriç an, Mexican	gin? (Specify n, Puerto Ric	Yes or No- an, etc.)	14	4. Race - Ame Black, Whit			
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	and Heal	3	Edna A. Keys 20a. Method of Disposition	er (wife)		ace of Dispos	Westfiel sition (Name of	1	Du:			yland ation - City or	ZIZZZ r Town, State		
mo	Page nent o ant: If ary or		1 ☐ Burial 2 🛣 Crema 4 ☐ Donation 5 ☐ Oti					natory or other place Service C		10/5/	2010		-	aryland		
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot once.		21. Signature of Funeral Serv	rice Lic	ee)	a	22	Name and Addres	ss of Facilit	by Duda	-Ruck	Funer	ra1 Ho	me of undalk, Inc.		
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89 ×	eath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome of			Ectopic pregnanc	°V			23	d. Date of de	elivery		
. Bo	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 Pregnant at 9 Unknown			Other (specify)					Month	Day Year		
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Division of Vital Records,	he law l te has t age 2 s	Completed									24a. Was a autop perfor	sy med.	prior to death?	utopsy findings available completion of cause of s		
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Ţ	Physician; this certific ral director,	년 :	1 Yes 2 No 27. Manper of Death	<u> </u>	Hospital: 1 ☐ Inpatie 28a. Date of injur	1	R/Outpatient 28b. Time of		4	ursing Home	7 3		Other (Spec	cify)		
o uc	nding ath. ; After e fune	cate	1. Natural 5 □ Pe	ending estigation	(Month, Day	Year)	injury	28c. Injun work M 1 🗆	yaı :? Yes 2 ☐	- 1	. Describe ho	ow injury o	ccurred			
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۵	To the Hospital or Attending Physician; The law within 24 Lours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s.		29a. Certifier 1 Certi	ying Phys	ician: To the best of	my knowle	dge, death o	ccured at the time	, date and p	place, and d	ue to the cau	ise(s) and i	manner as st	ated.		
	the Ho hin 24 I the Fu npleted	Medical	only one 3 Certi	ying Nurs	ner: On the basis of exe e Practioner: To the l	amination best of my l	and/or investi knowledge, d	gation, in my opinic eath occurred at the	on, death oc e time, date	ccurred at the and place, a	time, date ar ind due to the	nd place, ar cause(s) a	nd due to the and manner as	cause(s) and manner stated stated.		
	Vit Co		29b. Signature and title of ce	tifier U.	nicken	SUE:	Can	29c. License	e number	029	2	29d. Date :	signed (Monti	h, Day, Year)		
			30. Name and address of per	son who c	ompleted cause of de	eath (Item 2	23a) (Type, Pi	rint)	(0	7, ,	<u> </u>		-110	- 1 - 1 - 1		
	Stat		Ullan HUM 31. Date filed (Month Day Ye	ickc	AUT VI	r's Signa	3700	Loch RA	USN t	owal	BAH	mok	E, MD	21218		
	Registra		OCT 0 6	2010	Cenyua	A.	par	Kes								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Klar 201^{Year} Roma Lee 3:30 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Brightview Assisted Living 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Mayonta Day 912 ORTANoma Director 579-22-0171 98 Yrs Usual Residence of Decedent show 10a. State 10b. County ld be filed within 72 hours after death with the Maryland Mental Hygiene. than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 912 S. Rolling Road 21228 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2 Secretary Federal Government event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Ε. Reynolds George W. Simmers Marv permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Lavin (daughter) 9 Park Drive, Catonsville, Maryland 21228 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/4/2010 Glen Burnie, Maryland Signature of Funer 22. Name and Address of FacilitySterling Ashton Schwab Witzke Tuneral Home of Catonsville Inc. 1630Edmondson Ave. Catonsville, Maryland 21228 40080 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Fub vost Immediate Cause (Final Physician/ Monax disease or condition 1Pavs Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): and I-transit Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 House 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autonsy 2 No Yes 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di

Baltimore, Maryland 21215-0036

2 🔑 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA

examiner' 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Investigation

Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day. Year)

37573

City or Town, State)

October

4,2010

30. Name and address of person who comple d cause of death (Item 23a) (Type, Print)

determined

Day, Year

OCT 0 6 2010

MD 2835 YIA15 Zef

31. Date filed (Month State Registrar

Certificate: To

Medical

4 Homicide

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Michael Gordon King 10/01/2010 **Physician** 10:17 at /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Health & Rehab Ctr. Bethesda
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.
 1 1 / 2 / 1 9 5 4
 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 219-64-6073 55 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Bethesda MD Montgomery TYYes 2 □ No Director 10f. Zip Code 20814 10g. Citizen of What Country? 10e. Street and Number USA 5721 Grosvenor Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled 18. Mother's Name (First, Middle, Maiden Surname)
Marjorie Jean Kendig 17. Father's Name (First, Middle, Last) Be Ralph Gordon King ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11020 S. Glen Road, Potomac, MD 20854 19a. Informant's Name/Relationship (Type. Print) Nancy Futrell / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey crem. 10/6/2010 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service LicenseeDorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death errhosis of Immediate Cause (Final disease or condition resulting in death) Unknown **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Encephalopathy Hepatitis C 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
1 Natural
2 □ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hospital within 24 hours a To the Funeral C

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

0

29c. License number

D43121

HOWDHURY, MD: 1526 DINO DRIVE, BURTONSVILLE, MD 20866.

29d. Date sigged (Month, Day, Year)

10/011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>010</u> Month Year Physician/ 10:08PM Kathryn Mae Korman Oct Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) 2-18-1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours 1 ☐ M 2**X** F 76 214-30-1911 Director MD. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Carroll Finksburg MD 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number USA 128 Lassiter Circle 21048 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates 3 KWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Tailor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ralph K. Morelock, Sr. Erma Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 s f Health i 804 Medinah Circle, Westminster, MD Michele L. Selby-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/7/10 Finksburg,MD Evergreen Mem. 22. Name and Address of Facility Fletcher Funeral Home 254 East Main St., Westminster, MD 21157 Signature Fyneral Service Licensee tillen homas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IE FEMALE ed by the attendin detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death P.O. I cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 the Hospital or Attending Physician; The 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 2 No မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No 24 hours after death. Funeral Director: A Investigation the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD Wilbur Kuo, 295 Stoner Ave. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10/06/10 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month C Year YUNG MOD 0/04AM 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death GENERAL HOSPITAL COLUMBIA Houmpo COUNTY HOWARD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 □ F (Month, Day, Yea Director OREA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 □ No 10g. Citizen of What Country? Funeral NORMAN Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2. Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important; If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or CAMA 21. Signature of Feral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final SMALL CELL LUNG CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner EFFERSION PLAURAL Sequentially list condulons, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the burial-transi PN FUMONO A To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No detached g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director, After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATIVEY HAILURE 1 Yes 2 No 3 Probably 4 Unknown TACHICANDO A 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Investigation 6 Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059649 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 HILLOWY RIDGE RD, CULUMBIH MD 21044 KECHUKNU DAMIAN MBONU, M. D. 31. Date filed (Man 3% Registrar's Signat State

Registrar

Please Type of Printip Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death MORIEC If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5-10-1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Country/KOREA 88 Director iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Funeral Director 1 Ar Yes 2 □ No MONTGOMER 10e. Street and Number 10g, Citizen of What Country? KORDI 20905 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Completed by "natural", or 1 Never Married 2 Married 1 ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Me Loal Jury or other traumatic event the Loal Jury or other traumat 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) SOYERNMENT Elementary/Seconday (0-12) College (1-4 or 5+) TRANSPORTATIOI Be 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090/ 19a. Informant's Name/Relationship (Type, Print) Department of Healt Important: If item 2 any injury or other t Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SILVER SPRING . Signature of Funer sice License 22. Name and Address of Facility HowEZ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury as the burial-transit signed by the attending physician and be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIFFICIL 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sompleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definying injection in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59418 28,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLUYEMISI MONTGOMERY GENERAL HOSPITAL ADEWUNMI, MD 31. Date filed (Month, Day, Year) OCT 0 6 2010 Registrar's Signa

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lawrence Gertrude Catherine Medical or Location of Death 4c. County of Death **Examiner** Birth Day, Year) 26 Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Days Hours 1 □ M 2 ▼ F 218-22-7160 83 Director MD Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21201 1100 Pennsylvania Ave Apt 1303 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonee. 1 ☐ Yes 2 X No Specify. Black Specify: 3X Widowed 4 ☐ Divorced Completed Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Assembler Proctor & Gamble Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Gaither Benjamin C. Gaither 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3612 Eldorado Ave, Baltimore, Md 21207 Chester Lawrence-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland National 10/7/2010 4 ☐ Donation 5 ☐ Other (Specify) Laurel, 21. Sign vure of Funeral Service Licen March F/H West Wabash Ave, Baltimore, Md 21215 Part 1 Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. 23a. Part 1 mmediate Cause (Final disease or condition Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatien 28a. Date of injury ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Marther of Death 1 ANatural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I

> State Registrar

29a. Certifier

29b. Signature

(Check only one

062010

who completed cause of death (Item 23a) (Type

32. Registrar's Si

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

10/1/10

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Matthew Lahner		Pie		or Print in B e of Maryland								giaig	€.		
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Medical Examine		Matthew	J. La	hner							Month October 2				1405 hrs
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants I file m 27 is marked other tran "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. TO Be Compiled by Elineari Director	-	Mark W.	Lahner	/ Brother		1	911 Suf	ffolk	Road,	Fi	nksbur	g, I	Maryland 21048		
re, rand I and Health	Ī	20a. Method of Dis		2 Demoual from P			Disposition (Na ry or other place		metery,		Date	20c.	Location - (City or T	own, State
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Baltimore, permit. Pages I ar Department of Hes Important: If ite			neral Service Lic				22. Name an				bard E				
	1	23a Part I Enter th	a disease of cor	mplications that cause	the death	Do not									and 21229 Approximate Interval
Physician /Medical	ł	failure. List on	ly one cause on	each line.		i. Do not	eriter the mode	e or aying	, such as care	alac or i	espiratory ar	1031, 3110	ock, of fical	Ì	Between Onset end Death
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Box 68760, e death certificate be the attending physici ed for use as the buri-		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day										ay Year			
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Division of Vital Records, tal or Attending Physician: The law require and age from the form this certificate has been siled in by the funeral director, page 2 should be artification: To Re Commission	Certification:	3 Suicide	6 Could no	ot be	njury - At h	iome, farr	m, street, facto	ry, office	building, etc.	2	8f. Location or Town,		and Number	or Rura	al Route Number, City
ospita hours ly fille		4 Homicide 29a. Certifier		(Opcomy)	leanvila	daa daasii			-11-1						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burificial for the function. To Bo Completed by Dhysician/Model	Medical	(Check only		ician: To the best of r ner:On the basis of ex	amination a										
To To	Ě	29b. Signature and	title of certifier	and manner stated			2	9c. Licen	se number			29d.	Date signed	d (Mon	h, Day, Year)
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10-07532 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stanley Lipscomb State of Maryland / Department of Health and Mental Hygiene 2010 31217 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ Month Day October 1, 2010 Medical Examiner tan 0216 hrs SCOMB 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Foreign Vary In 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Days Hours Months Director land 5 2-70-955 2 F Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits s 23a or 28a-f show se notified at once. 1 Yes 2 No imore . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

rent: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmaite event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Janhol 21212 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 White etc Yes Specify: Black 4 Divorced If Yes, Give Year Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Father's Name (First, Middle, Last) Be aro Scom 19a, Informant's Name/Relati Inship (Type, Print) 19b. Mailing Address (Street and Number or Ivan 4702 scom b 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) Burial 2 Cremation 3 Removal from State Cremator Donation 5 Other Specify: Sonal re of Funeral Service Licer 22. Name and Address of I **Physician** Part I. Enter the disease, or complications that outset the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval failure. List only one cause on each line een Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED signed by the attending physician I be detached for use as the burial AMENDED 23a, PII, 27, per ME g909 11/5/10 TT P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death Live birth Ectopic pregnancy Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Diabetes mellitus Completed of Vital Records, this certificate has been a il director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica 26.Place of Death (Check only one) examiner? Hospital: 1 Other₄ Inpatient 2 PR/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Natural Pending 1 Yes 2 No To the Funeral Director: completely filled in by the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 1, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature State OCT 06 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7PM core ZOID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** paltimore favette HIMOTE Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** Age (In yrs, last birthday) 1 □ M 2 🗶 F Days (Month, Day, Louisiana Months Min. 550-38-5237 Director 80 Feb 13. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/A Maryland 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 USA 2320 East Fayette Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) the City of Baltimore Gov't. Disbursements Accountant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatin even Page 1 and 2 should be Leon Gray Hazel Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 South Augusta Ave., Baltimore, Maryland 21229 Saundra L. Montoya (Daughter) Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/8/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 21. Signature of Fureral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) piratoru Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Investigation Could not be completed filled in by the Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person pleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 032010 9:11 AMM Nancy M. Myers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Upper Chesapeake Medical</u> Center Harford Air If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X** F Days Hours Country) Maryland 03/14/1929 Director 220-26-2720 81 Usual Residence of Deceden 3a or 28a-f show t be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Baltimore Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8620 Kelso Drive - #302 D 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify. Specify: White "natural" Completed 3 ☑ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Homemaking Own Home Be ed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ္ be f Emma Magdalene Hinie William Evertt Dust 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21085 Jackie Krankowski (daughter) 1515 Clayton Road - Joppa, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Evan Luth Church Cem. 10/08/2010 | Baltimore, Maryland 21. Ig a re of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical 1700SM# IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Month Year Day Pregnant at time of death 9 Unknown page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying/cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? Yes 2 1 No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be B 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ₩ No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Plant
 24 hours after death.
 Funeral Director: After the 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No. 1 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Cew, mi 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 32. Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mcdaniels September 30 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Harbor Baltimore 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland **Funeral Director** Baltimore 1 XYes 2 ☐ No Maryland 10f. Zip Code 10g. Citizen of What Country? 21205 E a.st 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: Black Year or Dates. other traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Rent-A-Center sistant Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Morgan McDariels Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, y or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State Baltmore Cemetery 4 Donation 5 Other (Specify) Trinity 21. Signature of Funeral Service Licensee 22. Name and Ad r ss of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ udden disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Arrythmid Sequentially list conditions, if any, leading to in modileto cause. Enter Underlying Cause (Disease or linjury List to for se a consecusiona o To the Funeral Lirector: Hiter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 Yes 2 g 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alcohol 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 🗌 Yes 2 💢 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury X Natural 5 Pending 1 🔲 Yes 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Lirector: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) September, 30, 2010 Prantea Hashemu RES OOL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Harbor

32. Registrar's Signature

Hashemi

filed (Month, Day, Year)

DCT 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0725 M ache Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City. Town, or Location of Death Samaritan Hospital timore ecurity Number Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Hours Min Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 ☐ No 1+ imove Mariland 10e, Street and Number ò 10f Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 21206 115A items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces? 1 ☐ Yes 2 🗵 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married P. Completed by 1 ☐ Yes 2 No Specify: If Yes Give "natural" 3 Widowed 4 Divorced ack Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Health rivate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Mile Md 21206 Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, injury or Park Kandalstrum Md 10-11-10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Ave Balton, Md. 21202 Funera Home-East 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, Due to (or as a crinsequence of) O. WE D 10 COCCUS Poday Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of) attending physician Physician/Medical for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the aid be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed 2 XNO certificate 1 Yes Yes 2 No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 **FBCY**

DHMH 17 Rev 7/2009

State

Registrar

OCT 0 6 2010

32. Registrar'

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#26perPHYS. G908.10/6/2010 WS State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 3. Time of Death Month Year Physician/ Patricia 2010 Ann Minnick Septembe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2521 S. Snyder Avenue <u>Baltimore</u> Edgemere Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □XF Months Hours Min. 62 Yrs 220-50-1725 Director Sept. 1948 Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location **Funeral Director** 1 ☐ Yes 2 🛣 No Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2521 S. Snyder Avenue 21219 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes : If Yes, Give 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) 7 Years Walmart Corp Sales Associate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Virginia Elizabeth Woods Rufus Andrew Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 1738 Melbourne Road Tina Dunn (Daughter) Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns: 9/29/2010 Middle River, MD Signature of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 5 7922 Wise Dundalk, Maryland Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions Examiner any, leading to immediate cause. Enter Underlying for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 E 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed' 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify, 2 🗖 No ည ER/Outpatient 3 DOA patient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d, Date signed (Month, Day, Year) 29b. Signature ditte of certifie

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Gwendolyn Morris 1.0 2010 06:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery <u> Holy Cross Hospital</u> Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 - M 2 - F (Month, Day, Hours Year) **Director** 577-04-3187 88 08 OÎ Jamaica Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-1 shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Burtonsville 1 ☐ Yes 2 X No Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? #301 Funeral 20866 Terr 3504 Green Castle Ridge U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify: Specify: 3 X Widowed 4 ☐ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 8th grade College (1-4 or 5+) Domestic Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Anderson George Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ridge Terr #3 Md 208€6 <u>Green Cas</u>tle Lincoln Morris-Son 3504 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 10/9/2010 Woodlawn, 21. Sign ture of Funeral Service License March F/H West Serrall 4300 Wabash Ave, Baltimore, Μd 21215 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ediate Cause (Final Physician/ Cardiopulmonary Arrest
Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transil Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Abdominal Abscess 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? Ruptured Appendix 24a. Was an performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖺 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/3/2010 D0063343

State Registrar

3

Glen Road, Silver Spring, Md 20910

Forest

32. Registrar's agnatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month.

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		For		State of M	arylan				lealth and I	Mental Hy	giene)		
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Physicia Medic			(First, Middle, Last) iam T. M	elton,	Sr.					2. Date of De Month 0 C+0 b	Da	4, 200	3. Tir	me of Death
Examin	er	VA MAKY			RES	STEM		wn, or	Location of Death		40	Ceci L	th	
Funeral Director		5. Social Security Num	mber 6. Sex	7. Ag		st birthday) Yrs.	If Under 1 Months [Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bird July			thplace (Si	tate or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	MD	n/a		10c. City, Town or Location Baltimore									de City Limits Yes 2 No
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		11. Marital Status 1 Never Married 3 Widowed 4	d 2 Married	2. Was Decedent of Armed Forces? 1		I 14	Vas Deceden Yes, specify	Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	e, etc.	an,
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d 2 shoulk alth and N 27 is ma r trauma		19a. Informant's Nam Naomi Me	ne/Relationship <i>(Typi</i> elton (w	ife)		3308	g Address (S Ramor	itreet a	Ave. Ba	al Route Numbe	r, City o	t Town, State, Zi 1213	p Code)	
Page 1 and nent of Hei ant; If item iry or othe			sition Cremation 3 F The Company of	emoval from State	C.f	lace of Dispo emetery, cren	natory or other	er place	Oct.			ocation - City or ngsMil		
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nysician Medical Examiner	/Medical Examiner	23a. Part 1. Enter the shock, or heart i Immediate Cause (Fii disease or condition resulting in death) Sequentially list cond	failure. List only one inal		m.E	ence of):	the mode of						Appro- Interva Onset	ximate al Between and Death
ite be executed hysician and he burial-transit		cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): D. AbLts Mell; to S Due to (or as a consequence of): Due to (or as a consequence of):												
To the hospital or Attending Pressions: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 Yes 2 9 Unknown		Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year					
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aing rnys th. After this of funeral dir	Certificate: To	1 Yes 2 2 27. Manner of Death 1 Natural 2 Accident	1 ☐ Inpati 28a. Date of inju (Month, Da	28c. Injury at work?				ne 5 Residence 6 Other (Specify) 8d. Describe how injury occurred						
Hospital or Attending P 24 hours after death. Funeral Director, After t sted filled in by the funera			Investigation 6 Could not be determined	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number of Rural Ro				Number,	
ne Hospira in 24 hours he Funera ipleted fille	Medical	(Check 2	Certifying Physic Medical Examine Certifying Nurse	er: On the basis of e	examination	and/or invest	igation, in my	opinio	n, death occurred a	at the time, date a	ind place	e, and due to the	cause(s) ar	nd manner stated
To the comple	~	1 Co de discol i MOI e de									(Month, Day, Year)			
		30. Name and address	ss of person who con				rint)							
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PHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year FRANK MAZER AM Medical October 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai of Baltimore City N/A**Funeral** If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 1 F Days 0970271919 Director 212-09-4742 91 MD Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Examiner must 8 OAK HOLLOW COURT 21208 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, . or þ 1 Never Married 2 Married Black, White, etc. within 72 hours after Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours afte Health and Mental Hygiene. tem 27 is marked other than "natural", 1 Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced Specify: WHITE event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) FRANK LEONARD Elementary/Seconday (0-12) College (1-4 or 5+) HABERDASHER UNIVERSITY SHOP Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HYMAN MAZER **GERTRUDE** COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONI MAZER FIELD/DAUGHTER 4921 CLOISTER DRIVE, ROCKVILLE, MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of
Important: If it
any injury or o 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ARLINGTON CHIZUK AMUNO 10/05/2010 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. Onset and Death disease or condition Medical 2 weeks resulting in death) Due t (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying meumonia Examiner bue to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month signed by the a d be detached f g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Hypertension, asthma, COPD Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛕 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be after death 3 Suicide 4 Homicide within 24 hours after des To the Funeral Directon completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number KES-000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Graham MD 31. Date filed (Month, Day, Y State

() DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month PAIK HYUN KWANG Seplenta .04 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 40WARD UMM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) KOREH 1 🗷 M 2 🗆 F Months Days Hours Min. 220-96-873 Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Was Decedent of Hispanic Origin? (Specity Yes or No-if Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give or Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: ASIAN "natural", 3 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmets. Elementary/Seconday (0-12) College (1-4 or 5+) APMINISTRATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other pla TIMONIUM, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line, Immediate Cause (Final Onset and Death Physician/ Medical disease or condition resulting in death) Due to (or as a consequence of): **Examiner** schentic Thro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine for use as the burial-transi attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be execut that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year 1 Yes 2 g within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached it Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 🗌 No 1 🔲 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 ann

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

QCT 0 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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CEDAR LANE, COLUMBIAMD ZIO44

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Donna R. Pollard		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Pea No. 2010 3122											
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Deali		2. Date of D		-	3. Time of Death				
Medical Examin		Donna Renee Pollard 4a. Facility Name (if not institution, give street and number)	or Location o		September 24, 2010 2308								
		Prince George's Hospital		4b. City, Town, Cheverly	or Location C	oi Death		e George					
Funeral Director		5. Social Security Number 5.79 - 96 - 9269 6. Sex 1 Mm 2 F 45	rs. last birthday) Yr:		ear If Unde	er 24Hrs. 8. Date of Min. 09/1	Birth(MM/DD/Y	5 Foreig	thplace (State or notify)				
à	Ī	Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Loca	tion					10d, Inside City Limits				
id how as			shingto						1 Yes 2 No				
the Marylar a or 28a-f s tiffed at on	Director	10e. Street and Number 5513 C. St., SE		10f. Zip Code 2001		10g. Citizen o	of What Cour	ntry?					
death with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 N	lf Y	U.S. 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri				can, etc.) White, etc.					
s after ral", o	ă	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 🗍	Yes 2K N			Specify: Black						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 1 1 t h	during m	16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retired Domestic									
1215-0C be filed with Hygien rrked other went, the M	<u>8</u>	17. Father's Name (First, Middle, Last) Ernest Pollard	ia Greer	dle, Maiden Sumame) N									
MD 27 nd 2 should ulth and Me m 27 is ma		19a. Informant's Name/Relationship (Type, Print) Charlene M. Green/ Sister	125	P. St	SW W	ber or Rural Route N ashingto	on, DC	200	24				
imore, Pages l ar nent of Hee ant: If ite	1	20a. Method of Disposition 1 Shurial 2 Cremation 3 Removal from State 4 Nonation 5 Other Specify: Crematory of the Specify: Contact of Disposition (Name of cemetery, crematory of other place) 10/12/10 Washingto											
Balt permit Depart Impor	1	1. Signature of Funeral Solvice Licensee 22. Name and Address of Facility 2001 Dunn&Sons 5635 Eads St. NE Washingt											
Physician / /Medical	23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a.												
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)		01430414				Death					
	ا پ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	and of the contract of the con										
	Ę₩	cause. Enter Underlying Cause (Disease or injury that initiated	124										
cuted und transit	events resulting in death) Last Due to (or as a consequence of): d. AMENDED item 23a,part II,27 per ME 1/18/11 G911 eg												
O, be exe sician a	edical			11,2/ pc	er MŁ	1/18/11 6	i911 eg						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 1 Unknown 1 Unknown 1 Unknown 1	pregnancy	23d. Date of delivery Month Da									
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p, P.C	à l	Diabetes Mellitus	1 🗆 1	1 Yes 2 No 3 Probably 4									
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Vital Recc ysician: The lav his certificate ha director, page 2	e l	25. Was case referred to medical examiner? [Hospital: ,] Inpution 2			IOthor:	Check only one)	7						
n of Vi	1 V Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 F P P P P P P P P P P P P P P P P P P							Residence 6 Other:					
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i	Certification	Accident 1 Yes 2 No 1 Yes 2 No 2 No 2 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
To the Hospit within 24 hour To the Funers completely fill	4 Homicide determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as one) 29b. Signature and title of certifier 29c. License number 29d. Date signed												
To the within To the comple	Mec	29b. Signature and fille of certifier and manner stated.	se number	29d. Date signed			th, Day, Year)						
				O.C	.M.E.		Septemi	oer 25, 20	110				
D. OCME	_ [30. Name and address of person who completed cause of death (Ith Mary G. Ripple MD. Deputy Chief Medical Ex	,	Penn Stree	t, Baltimo	ore, MD 21201							
Stat Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature Article	0									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ TARK Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1289 Magothy Road Pasadena Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. **Director** 220-74-1652 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗖 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1289 Magothy Road 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Completed 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Inspector Baltimore Gas and Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Matthew Platt, Jr. Beatrice Cufflev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheri L. Platt (Wife) 1289 Magothy Road Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Atlantic Cremation 4 ☐ Donation 5 ☐ Other (Specify) 10/07/2010 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee McCliffy Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Lause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one)

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signati

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Bernard Prouser 8:10 A М sept mber 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Hours Min. 05/113711920 1 🖳 M 2 🗆 F 90 MD 218-05-7414 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a State Director 1 🗌 Yes 2📈 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3317 KATEWOOD COURT 21209 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever Armed Forces?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSkajapahreM.D D0057465 9130/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD, 21209 2835 Smith AV- 5-203. N.S. Rajapakse, MID 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 28,2010 Physician/ Month <u>Violet R. Reed</u> September 9:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Quail Run Assisted Living Social Security Number 6. Sex _____ 7.7 Balto Parkville Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** If Under 24 Hrs. 8. Date of Birth 1 □ M 2🛣 F March 16,1908 Month: Hours **Director** 102 179-10-1317 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Md Balto. Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9900 Walther Blvd. 21234 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isaac E. Taylor Olive Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Werner 4423 Wynn Road Balto. Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Reedsville Cemetery 10-02-2010 Schuylkill Haven,, Pa. 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Juneral Solvice Lice Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final THEROSCLERO TIC CARDIDVASCULAR Onset and Death Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine CEREBROVASCULAR ACLIDENT for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Vother (Specify) Assited 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury 1 Natural 5 Pending work?
1 Yes 2 No Division 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 □ 3 □ only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) annda KI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Dundalk MD 21222 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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DHMH 17 Rev 7/2009

State Registrar 30. Name and add

JACKIE JONES,

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

who completed cause of death (item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 06:50 PM 04 2010 tenrietta October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Baltimore Baltimore Cit 0 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye May 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral Country) Kansas (it 508-22-9049 1 🗆 M 2 🗗 F Hours Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City Town or Location Completed by Funeral Director 1 Yes 2 No timole 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) eticiar Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Whittie 2010 Memoria 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service Licens Bathmer. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a conte uence of): Physician/ disease or condition resulting in death) Medical Examiner days Sequentially list conditions, Examine Due to (or as a consuctionce of) cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 7 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CAD 24a. Was an CABG autopsy performed? Yes 2 No prior 1 🗌 Yes 2 🕱 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie October 04, 2010 Januel MBBS RES-000 9

Registrar
DHMH 17 Rev 7/2009

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State

Namita

31. Date filed (Month, Day, Year)

0 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBBS

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 **Physician** KLOBEI 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner .OUT 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 3irthpia Country) WA 7. Age (In yrs. last birthday) 57 Yrs. If Under 1 Year Social Security Number Min. Months Days Hours 117/4/1952 **Funeral** 1**⊠**M 2□ F unkr Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Exp. of content traumatic event, it. 10c. City, Town or Location 10b. County 10a. State Frederick 1 XYes 2 □ No Frederick MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21704 1115 Providence Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Res 2 □ No1970-1973 If Yes, Give Year or Dates Coast Quard 11. Marital Status Specify: White 1X Never Married 2 ☐ Married 1 ☐Yes 2 ☐No Specify Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Shipping Elementary/Secondary (0-12) Security Guard 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harriet Hardaway Be Robert Frank Recht ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) OR 97013 1594 N. Redwood, Canby, Eric W. Recht / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. Date 20a. Method of Disposition Woodbine, MD 10/6/2010 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oscleratic ea her **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical the attending ph 23d. Date of delivery nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No ned by the a o. 9 Unknown 9 Unknown has been signed by 2 should be detach 23e. Did tobacco use contribute to the cause of death? ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No page 1 ☐ Yes 2 1 ☐ Yes giab certificate 105 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide

Division of Vital Records, or l the Hospital

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within 24 hours a To the Funeral C

Medical

Dav. Year)

29a. Certifier

et person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ 5:00 AM M October 2010 Richmond Certrude Cleo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium <u>Stella Maris Hospice</u> 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min (Month, Day, Y 6/8/192 North Carolina 1 ☐ M 2X F Director 213-36-5034 88 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 X No <u>Parkville</u> Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral S. 9318 Shadycreek Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental h Important: If item 27 is marked oth any injury or other trans-17. Father's Name (First, Middle, Last) 2 Blinson Wilkins Gertrude James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9318 Shadycreek Way Parkville, Maryland 21234 <u>Donna Richmond (Daughter in Law)</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 10/7/2010 4 Donation 5 Other (Specify) Overlea, Maryland Gardens of Faith Mem; Gard. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any in Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Deinentia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical The law requires that the death certificate be Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? ate has been signed by the atte page 2 should be detached for I 5 Other (specify) Pregnant at time of death Unknown 9 Unknown GERTRUDE RICHMOND Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 X No certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 은 this 28a. Date of injury (Month, Day, Year) eral Director: After th 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d, Describe how injury occurred 1X Natural 5 Pending hours after death 2 Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 10/5/2010

State Registrar 32. Registrar's Signature

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARLETTE GEPP, CRNP

31. Date filed (Month, Day, Year

OCT 0 6 2010

State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1:00 A M 2010 Redifer Sr. October 3 Winfred /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Dunlap Road Pasadena 8. Date of Birth (Month, Day, Year)
ADril 30 1929 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Days Min 1∏ M 2□ F Yrs. Georgia 81 **Director** 215-30-1862 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the the Mental Evaryland and injury or other traumatic event, the the Mental Evaryland and injury or other traumatic event, the the Mental Evaryland at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 ☐ No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1101 Anglesea Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA Truck Driver Hemway Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Boddiford ဥ Redifer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 21224 1100 Anglesea Street Baltimore, Glenn A. Redifer (Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 7. N Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet, Cem.: 21. Signature of Fuperal Service License ²² Name and Address of Facility. W. Dabrowski/Chojnacki Funeral Homes P.A. lash U nees 1005 Dundalk Ave. Baltimore, Maryland 21224 Approximate Interval Between Onset and Death 23a. Prit1. Enter the disease, or complicity in sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only on chause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🖾 No 1 ☐ Yes 2√☐ No 1 Tes Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifics 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 216 PUR Ly Other: 4 Nursing Home 5 Residence 6 Definer (Specify) PASA day 1∐Yes 2ไ∏No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MOUNTAIN RD PASA 30a Name and address of person who completed cause of death (Item 23a) (Type, Print) GARG 4304 MO 32. Registrar's Signature State OCT 0 6 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ RUTH DELORES SZYMANIK P.M 7:00 10 2010 02 Medical 4a. Facility Name (if not institution, give street and number)
UNION MEMORIAL HOSPITAL 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral VIRGINIA 1 □ M 2 🛛 F Hours Min. 233-50-2856 78 Yrs Director W. Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location 10d, Inside City Limits Director BALTIMORE MD ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 6800 GOLDEN RING ROAD APT F 21237 U.S.A. . Page 1 and 2 should be filed within 72 hours after death vernet of Health and Mental Hygiene.
Tant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ATTENDANT 12 LAUNDRY MAT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL DAWSON ALICE UNKOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS SZYMANIK/SON TORHAT CT APT K ESSEX, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott
once. Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 10-8-2010 OWING MILLS 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL 21. Signature of Funeral Service Licenses 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ sel disease or condition resulting in death) Sis 4 hours Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate Examine Due to for as a nonsequence of: if any, leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year been signed by the s should be detached 9 Unknown 9 🔀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has to page 2 s autopsy performed? After this certificate 2 X No 25. Was case referred to medica funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 24 hours a er death. Funeral Director: A 2 🗌 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, þ 4 Homicide determined City or Town, State) completed filled Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Freig 41 AT 243 8946

Registrar DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

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10,02,2010

, Ballimore, MO 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 LORRAINE B. SCHIER ด์ให 7:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolitan Assisted Living <u>Anna</u>polis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 Hours 10/1 Day 214 12 2503 88 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 484 Ruffian Court 21409 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) High Point Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Elementary School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Monaco Neberding Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valarie Smith - daughter 484 Ruffian Ct. Annapolis, 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation Ent combiners to 4 Donation 5 Cher (Specify) Glen Haven Mem Pk 10/4/2010 Glen Burnie, MD 22. Name and Address of Facility GJ Gonce Funeral Home 169 21122 Riviera Dr. Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the otherwise. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ASSISTEDIVING Hospital Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 😥 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier

Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 40 **Physician** 707 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (Stand Country) 8. Date of Birth Month, Day, If Under 1 Year (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F Days Hours Min 3 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Medical Everning must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2 No Director MD. Of, Zip Code 10g. Citizen of What Country? 10e. Street and Number 15.A. EAS 1222 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No 3altimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be EORBE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 19a. Informant's Name/Relationship (Type. Print) SCHOFF 20c. Location - City or Town, State AREN OBINSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Buria! 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SKARDA.F-H 2829 HUDSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hyperteneica /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any locality to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed abeter burial-tran Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 24 hours after death.

Funeral Director: After this certificate has been signed by the fetch filled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical mpletely (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number M.D 00055171 02

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy E. Schuessler 10/2/2010 11:30A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore Catonsville Commons If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/6/1936 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 73 Maryland Director 213-34-6197 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show 10a. State 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 5 David Lee Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 2 White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7's.
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "ne eny injury or other traumatic event, If a Mealis once. Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aid Education 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Goodwin, Sr. Mary E. Ebert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 408 South Rolling Road, Catonsville, Maryland 21228 John G. Schuessler / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/6/2010 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 7 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myo dronke /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to lor as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year ☐Yes 2 No Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed' 1 □Yes 2 D 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 virsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number more Mille D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Miller

31. Date filed (Month, Day, Year)

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Douglas Anthony		isher, Jr I- For State Registrar	State	of Maryla		artment of artificate of		nd Mental	Hygiene	Reg. No	201	0	31240
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To wit To con	Me	29b. Signature and title of c	ertifier	and manner s	tated.		29c. Licen	se number		29d.	. Date signed	(Montl	h, Day, Year)
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7	ŀ	30. Name and address of pe	rson who	completed caus	se of death (Item	n 23a)					-		
\mathcal{Y}		Margarita Korell M	D. A	ssistant Med	dical Examir	ner 111 Pe	enn Street, E	Baltimore, M	D 21201				
Sta Regist		31. Date filed (Month, Day,)	ear)	32. Re	egistrar's Signat	Barkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Bepartment of Health and Wental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Siming Shen Day 4 Physician/ October 2010 4:07a M Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 01/05 D1934 Months Days Hours 214-63-4047 Director China Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important if item 27 is marked other than "natural" any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Potomac 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11511 Patriot Lane 20854 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black. White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: White Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Xinqyuan Shen XingLang Lu 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Eastleigh Drive, Plano, TX 75024 Lihua Shen / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crem. 10/7/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pokota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 2 shall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cholangiocarcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Cardiac Arrest Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (u) as a consequence of Exami Director. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No ည 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending Accident Suicide 2 | No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifyin Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Me in 1 I examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Me in 1 I examiner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title A 29d. Date signed Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 M.D., 8600 Old Georgetown Rd.,

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Atul Rohatgi,

31. Date filed (Month, Day, Year

10/4

MD

20814

Bethesda/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ruby Ruth Strosnider 11:15 AM Medical October 6 1 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 904 Cedar Crest Ct. Apt. H Edgewood Harford If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛂 F Days 227-28-2562 Months Hours Min. Aug. 20, 1926 Virginia 84 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 38a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 904 Cedar Crest Ct. Apt. H 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Private Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Bee Baldwin Maldeen (unk) Debord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Glassman / Daughter 904 Cedar Crest Ct., Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/7/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall | 22. Name and Address of Facility | Maryland Cremation Services | PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final lation Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury zheimer that initiated events resulting in death) Last Due to (or as a consequence of) nding physician a Physician/Medical physema P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 After this certificate Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \hbbeck{X} Residence 6 \subseteq Other (Specify) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work thin 24 hours after death.

the Funeral Director: After ompleted filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 00043909 nance

State Registrar 902 Averill Rd Joppa, MB 21085

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

phanie

nder

32. Registrate Signat

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND, ITEM#17perFH, G908, 10/6/2010 WS State of Maryland/Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Oct 4 10:08AM 2010 John William David Stoer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign Country)
MD 8. Date of Birth (Month, Day, Year) 6 – 21 – 1927 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Months M 2□ F 214-24-8637 83 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show MD Carroll Westminster 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 110 Timber Ridge Dr., Apt. 219 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 7 Is marked other than "natural", or iten traumatic event, the Medical Exentiner 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Detective Agency 12 should be filed within h and Mental Hygiene. 7 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be $Frederick_+$ Stoer Ada Deushea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 19a. Informant's Name/Relationship (Type. Print) of Health of Item 27 ly 410 Quiet Hollow Ct., Apt. L, Glen Burnie, MD David S. Stoer-son other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Department of Important: If it any Injury or o 1 ☐ Burial 2 XCremation 3 Removal from State South Carroll Crem 10/5/10 |Winfield,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Monices V. 254 E. Main St., Westminster, MD 21157 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYEDMA MULTIPLE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an this certificate 1 ☐ Yes 2 Z No abscers within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the I within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 3322 0 6 2010 30. Name and ad ss of person who completed cause of death (Item 23a) (Type, Print) 200 Memoria 4MANDEE JINOn 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar **ORIGINAL**

0.08 Am

0/4/2010

NHO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 01 2010 11:50A M SULDAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3717 MICHELLE WAY PIKESVILLE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. (Month, Day Year) 01/15/1924 $86 \, ^{Yrs}$ Director 188-18-1343 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d, Inside City Limits Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 4730 ATRIUM COURT, #455 21117 items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. P þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 🛮 Widowed 4 🗆 Divorced 'natural", Specify: Completed WHITE Year or Dates event, the Medica 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER **EDUCATION** and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ SOLOMON CANTOR IDA KATZ traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau JOEL SULDAN / SON 3717 MICHELLE WAY, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH SHALOM CEMETERY | 10/03/2010 | PITTSBURGH, PA re of Funeral Service Lice o ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Simal 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) 5 ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown ns certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? (SON'S 2 ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Special Control of the Contr this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of RESIDENCE) 28a. Date of injury (Month, Day, Year) 27. Manner of Deal 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signature d title of certifie 125039

State Registrar 30. Name an

DHMH 17 Rev 7/2009

9635 SMITH ALENUS

BALT.

who completed cause of death (Item 23a) (Type, Print)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09-29-2010 Physician/ 2200 P M Lora Lee Torgerson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Harford Bel Air If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Min. Hours 03^M21^{th, D}1^y9^y2²7 Kentucky 299-22-5703 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland the Medical Examiner must be notified at Director 28a-f MD Harford Fallston 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 21047 USA items 23a 2828 Charles Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Black, White, etc. Armed Force ō à 1 Never Married 2 Married 2 X No Yes 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White 3 ⅓ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. homemaker own home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ Sarah Newsome Arthur Savage permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic & 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1755 Gablehammer Rd Westminster Richard Torgerson (step son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bavview Crematory 10-02-2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir MacPhail Rd BelAir, MD 21014 610 W. 23a. Park 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death nlumomo Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Directo for as a nonsecuring of Cause (Disease or linjury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Physician/Medical I or Attending Physician: The law requires that the death certificate be a siter death.

Director: After this certificate has been signed by the attending physicia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ည the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practiciner. It is best of my model and the time date and claim and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date file onth, Day, Year) Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mont 04:12 AM Medical 4a. Facility Name (if not in titution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ente Baitemore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XX M 2 □ F Months Days Hours (Month, Day, Country)
Maryland 85 Director 218-14-2386 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 16 Upman Court 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give "natural", Year or Dates. 1943-45 3 X Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Retail Display Artist 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold C. Towns, Sr. Martha Ziegler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 Whitby Court; Catonsville, MD 21228 Diane Iacia Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gardens 10/9/2010 Marriottsville, MD 21. Signaure Juneral ervis 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a nonscouerine cry cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Box 68760 the attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? ģ otic heart Hospital or Attending Physician: The law requires of Vital Records, 1 🗌 Yes 2 🗆 No 3 Probably 4 Unknown Completed preumonia, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 - ER/Outpatient 3 - DOA မ this funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) work? 5 Pending Division death. within 24 hours after death

To the Funeral Director; /
completed filled in by the f Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign e and title of certifie 29c. License number

State Registrar 32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 3:40 PM Vancy October 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😾 F Oct 1, Day Year 2 218.28.5920 Months Days Hours Min. 78 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Sussex Millsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26053 Seagull Lane, 19966 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Mossberger Dorothy Feldner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Hornfeck- Daughter 424 Bathurst Rd. Catonsville, Md 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Moreland Mem Pk. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/2010 Baltimore, Md 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Servic . L. ensee MOIDSU Funeral Home of Catonsyille, Inc. N. 21220

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burialattending physician Medical Certificate: To Be Completed by Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

11050	Edilonason Ave.	Calumsvill	MC MC	17.70		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death) a. Immediate Cause (Final disease or condition a.	Activity Ven	tricular t	achyandie			
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	jaihre scond	M to B	00P	3 months		
if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Autt veral f Due to (or as a consequence of):				15 days		
d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ect 4 ☐ Pregnant at time of death 5 ☐ Oth	opic pregnancy ner (specify)		23d. Date of deli Month	ivery Day Year		
Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?		
DM type II thrombocytopenia		1 🗆 Yes 2	⊠ No 3 □ Pr	obably 4 🗌 Unknown		
thrombocytopenia		24a. Was an autopsy performed?	prior to death?	opsy findings available completion of cause of		
25. Was case referred to medical examiner?	26. Place of Death (Check o	only one)				
1 X Yes 2 □ No Hospital: 1 Inpatient 2 □ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hom	e 5 Residence	6 🗌 Other (Speci	fy)		
27. Manner of Death 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	work?	id. Describe how inju	ry occurred			
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	actory, office 28		Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigation only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at th	ne time, date and place	e, and due to the c	ause(s) and manner stated.		
29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month	, Day, Year)		
Haoli, MD.	Resoul	Octo	sper 0:	3 2010.		
20 Name and address of names who completed as on of death (from 22a) (Time Drint)						

Hanover St.

Baltimore,

State

Registrar

Hao 31. Date filed (Month, Day, Year)

OCT 0 6 2010

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Α. WATTS WILLIAM October 20ÎÖ 7:32A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 185 Riviera Drive Pasadena Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Nov. 26, 1 Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Days Months Hours Maryland Director 213-26-8446 80 1929 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Anne Arundel <u>Pasadena</u> 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b 185 Riviera Drive 21122 <u>U.S.A</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of the control of the contr College (1-4 or 5+) Elementary/Seconday (0-12) N/A Commercial Credit Credit Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus Watts Evelvn Loney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa C. Parks (Daughter) 902 Crofton Valley Court Gambrills, MD 21054 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery 10/07/2010 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licensee 23a. Part inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ AMEMOSELENDTIC CANISIONASCULAN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det ģ CARDIOMYOPATRY 2 No 3 Probably 4 Unknown Completed 1 Yes 01938713 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 24 hours after death.

Funeral Director, After this certifical leted filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and atle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 21776

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURLIAP, WD 8021 NO 32. Registrar's lignatur

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year

OCT 0 6 2010

RITCHIE MIBHWAY

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 17 per fh.g908,10/06/2010dhb #20b, perfil, G908,10/12/2010, WS
Amend Items 25,23a,28a-1 per me, g908,10/06/2010dhb Certificate of Death Registrar Amend#2per Phys, G908, 10/21/10, WS 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wilson 10:08 am Joseph Maurice Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore enmore Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) ate of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Hours Min. 10 09 Country) Director 53 214-76-4070 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is mared other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore 1 Yes 2 No MD 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 734 Linnard Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 5 1X Never Married 2 Married 1 Yes 2 No Specify: Yes Give Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Disabled Disabled 8th grade na Be 17. Father's Name (First, Middle, Last)
Joseph Wilson
Joseph Wilson 18. Mother's Name (First, Middle, Maiden Surname) Mary Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 734 Linnard Street, Baltimore, Margie Shird-Sister Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Ukn 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/7/2010 On-Site Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 300 Wabash Ave, Baltimore, . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Enysician/ mvncaraia isease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of lysician and re burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): CER Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the him Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. <mark>Other significant conditio</mark>ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural subject choked on bolus of 5 Pending 9:30 am n 24 hours after death. ne Funeral Director. Af noleted filled in by the fu 09/16/2010 1 ☐ Yes 2 No Accident Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2525 W. Belvedere Avenue, Baltimore, MD building, etc. (Specify)

Nursing Home determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401W. Belvedere Ave Baltmore, mb 21215 T HOS Degistral's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month Watkins 1:05 AM Arline 2010 Medical atoper 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospitou baltimore 6. Sex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 🗓 F Months Hours Min. (Month, Day, Year) 220-20-7670 Director 89 30 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Anne Arundel Glen Burnie MD 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral 23a 21060 U.S.A. 105 Arundel Corporation Road items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married ☐ Yes 2 ☐ XNo ō \$ 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) be filed within House 7th grade na Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Inez Brooks William Brooks . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Cherry Lane, Glen Burnie, Md 21060 Regina Richards-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/8/201d Cedar Hill Baltimore, Md 21. Sign at tre of Funeral Service Licensee 22. Name and Address of Facility
March F/H West IL me Baltimore, Md 4 300 Wabash Ave, 23a. Pari 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sholk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Pause (Final disease out andition resulting in death) Physician days Medical Due to (or as a consequence of): **Examiner** 40 days sectosia moid Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami burial-transi resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypeal burninemia malnutrition 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performe 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No. ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Acciden 5 Pending work? Investigation
6 Could not be 1 Yes 2 No Accident filled in by the 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical

State Registrar 29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Hao Lin

OCT U 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harbor Hospical

32. Registrar's Signature

within 24 the

1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3001

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) October 4th. 2010

21225

South Hanover Str. Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Angela Yarborough Woodard Woodard 7:40 A M September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore North West Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 ⋤ F Months Days Hours Min (Month, Day, Year) 212-48-1957 61 **Director** 1949 June22 MD Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Gwynn Oak 1X□ Yes 2 □ No MD Baltimore - Essex-10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ems 23a or r must be r Funeral 21207 104 Sunmar Ct. USA "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes X No Specify: If Yes, Give Specify: Black Completed 3 ☐ Widowed 4 ₩ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Hospital/Private</u> Nurse Be 17. Father's Name (First, Middle, Last)
Charlie Yarborough 18. Mother's Name (First, Middle, Maiden Surname) Viola Wilson ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shavon Torain (daughter) 2815 Essex Rd. Balto, Md. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State .Date cemetery, crematory or other place) ★☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem. Oct.8,2010 AnneArundel,MD Donation 5 - Other (Specify) nature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Breast Cancer Onset and Death Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be be to hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 4 Pregnant : 9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death?

1 Yes 2 No Yes 2 11 N 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 2 🗹 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending Accident
Suicide Investigation 24 hours after deat Puneral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ns Rajapahnem. D 9/30/10 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith AV-5-203, Bultimore, MD. 21209 N.S. Rajapakse, M.D 32. Registrar's ignatu State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#2PerPHYS, G908, 10, 6, 2010, WS

State of Maryland / Department of Health and Mental Hygien () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day 2010 ear Month 5:00 AM /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HIMOre If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Director Usual Residence of Decedent 10a. State 28a-f show 10c. Çity, Town or Location 10d. Inside City Limits notified at otting 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be r 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>ک</u> Specify: Specify: Black 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. BO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within h and Mental Hygiene. 7 is marked other than Elementary/Sacondary (0-12) College (1-4or 5+) injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Smith ျှ 19a/ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saxon Circle vera Department of Health Important: If Item 27 19rulung 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 NBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sovide Licensee 23 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2]]] No Other: 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA (4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address Suite Zey Janson 191 son who c of deat (Item 29a) (Type, Print) dive State Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

within 2

DHMH 17 Rev 1/2001

Leobradi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Objecti 31. Date filed (Month, Day, State SEP 2 3 2010 Registrar

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

mD, 7600 Carroll Avenue, Takoma Park, mD 20912

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D68005

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 31254 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **9** Physician/ 2010 Tina Marie Augusti 6:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 804 S. Schumaker Drive, Salisbury Apt. 3D If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Washington, DC 12/16/1966 Director 213-98-0338 43 Usual Residence of Decedent 28a-f show 10a. State 10b. County other traumatic event, the M-dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Salisbury Wicomico 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 804 S. Schumaker Drive, Apt. 3D 21804 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black White etc þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify White 3 Widowed 4 N Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 ial Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technical / Administrative 12 County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ Janet Patricia Bush John Urbano Augusti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Page 1 and 2 sh prent of Health a rtant: If item 27 is 1119 Resden Run, Salisbury, MD 21804 Janet P. Augusti (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State jury or 9/18/2010 Salisbury, MD 4 Donation 5 Other (Specify) Salisbury Crematory Departr Departr Importa any inju ture of Funeral Service Licensee Holloway Funeral Home, Professional Association 501 Snow Hill Road, Salisbury, MD 21804 dompson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouse and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Li retail 4 Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year the page 2 should be detached 9 🗌 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2. 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No 2 Accident М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ² □ 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print John 31. Date filed (Month, Day, Year) Registrar's Signatur State SEP 22 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** Ρ. ADKINS 0610 HAZEL 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Willomico Salisbury Rehabilitation + Nursing Ctr If Under 24 Hrs Hours Min. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vis. last birthday) **Funeral** Months Days Vear) 1 □ M 2 😾 F 96 Director DEC. 27, 1913 DELAWARE 213-22-6601 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it worked Examinating to motified at 1∭XYes 2∏No Director WILLARDS MARYLAND WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7324 CANAL STREET 21874 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS CLOTHING MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic even once. LEWIS **GEORGE** S. PHILLIPS MARY F. မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL L. HAMBLIN/DAUGHTER P.O. BOX 2063, SALISBURY, MARYLAND 21802 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/25/10 WILLARDS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) WILLARDS CEMETERY 22. Name and Address of Facility 21. Signat Juneral Service Licens HASTINGS FUNERAL HOME, SELBYVILLE, DE Approximate Interval Between Onset and Death Paled Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examine 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Examiner (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death nis certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 Ne 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed 1 □Yes 2 □ No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊡-Mo မှ 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c, License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

To the I

DHMH 17 Rev 1/2001

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Maryland

imore, I

Robins. William H. 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature 2010 park

200C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Ave.

Salisbury, M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER **Physician** 17, 2010 4:22 A M WILL LEONARD ALLEN SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S 7224 ANNAPOLIS ROAD HYATTSVILLE If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 25 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1947 Hours Months Days Min. 1∏ M 2□ F NORTH CAROLINA 237-72-8122 63 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1√Yes 2□No Examiner must be notified Director PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 20784 USA 7224 ANNAPOLIS ROAD Funeral 12. Was Decedent Ever in U.S. 13
Armed Forces?
1ÂgYes 2 □ No VIETNAM—
If Yes, Give
Year or Dates: —ERA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 6 1 ☐ Yes 2 No BLACK þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 Is marked other thar any injury or other traumatic event, the M <u>once.</u> GOVERNMENT COUNSELOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CASSIE MCCOY JUNE WILLIAMS ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANNAPOLIS ROAD HYATTSVILLE, MARYLAND 20784 JUDY E. ALLEN/WIFE 7224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/28/2010 ARLINGTON, VIRGINIA ARLINGTON CEMETERY 21. Signature of Funeral Service License 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND wane 20785 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? POST TRAUMATIC STRESS DISORDER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 1□ Yes 🛣 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify) ဥ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Injury 5 Pending investigation 1 🗌 Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed I Director: within 24 hours aft

To the Funeral Di

completely filled in within 2.

29a. Certifier

29b. Signature and title of certifier

Medical

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 KAREN ANN BLACKSTONE,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

#MD 33255

29d. Date signed (Month, Day, Year)

SEPTEMBER 22, 2010

31. Date filed (Month, Day, Year) SEP 2 2 2010

32. Registrar's Signature

Registrar

10-07125 Toivo John Anttila

p4~~

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Antti														
		1- For State Registrar		Cei	rtificate of	Death					g. No.	10.7	(D. II	
Physicia		Decedent's Name (First, Middle	e,Last)							Date of Death Month	Day Year	3. Time o		
ical Exami	Hei	Toivo J. And 4a. Facility Name (if not institution	ttila	umber)		b. City, To	wn, or Lo	cation of		September	4c. County of [l Death		
		11340 Lakeside Drive	., g	,		Hagers	town				Washingto	on		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	_	If Under		8. Date of Birti	(MM/DD/YYYY)	9. Birthplace (St	ate or	
Director		273-05-4661	1X M 2 F	93	Yrs.	Months	Days	Hours	Min.	March :	25,1917	Country Oh:	io	
		Usual Residence of Decedent												
w any		10a. State 10b. County		10c. City,	Town or Locati								de City Limits	
land f sho	Ď		ington			Hager		m		140	g. Citizen of What			
r 28a	Director	10e. Street and Number				Tol. Zip C] '				
ith the 23a o notifi		11340 Lakesio		cedent Ever in U	S 13 Wa	s Decedent	217		n? (Spec	ify Yes or No-		JSA American Indian	. Black.	
ath w items	Funeral	1 Never Married 2 M	arried Armed F	orces?		es, specify					White, e		, ====,	
fter de [", or er m		3 Widowed 4 Div	Yes 2X	No	specify:			Specify:	White	2				
ours a atura kamir	d by	15. Decedent's Education (Spe	or Dates: cify only highest gra	ide completed)	16a. Deceden	t's Usual O					16b. Kind of Busin	ess/Industry		
6 172 h an "n ical E	lete	Elementary/Secondary (0-12)	College (a army in					,	Gl. d				
withir giene.	Completed	12 17. Father's Name (First, Middle,	1 oct\			FO	rema		Name (F	irst Middle M	Sn: laiden Surname)	ipping		
15-	Be C		Anttila					anni		Krans				
212 uld be Ment mark c ever	0 B	19a. Informant's Name/Relations		19b. Mailing	Address					ber, City or Town,	State, Zip Code)		
e, MD 21215-0036 l and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once		0.102100 1.11001111									17225		_	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggine. Important: I file than 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 20c. Location - City or crematory or other place)											te	
Pages Pages sent o		4 Donation 5 Other S	_		enlawn	Mem.	Garc	lens	Sept	.21,20	10 N. K	inasvil	Le, OH	
Salti rmit. epartn nport jury		21. Signature of Funeral Service	Licensed	_						e, P.A		-		
	1	23a. Part I. Enler the disease, or	complications that	raused the death	Do not enter th	5 S.	Conc	coch	eagu	e St.W.	illiamspo	ort, MD	21795 imate Interval	
Physician /Medical		failure. List only one cause	on each line.				ayınıg, oc	3011 do 0d1	i dido or re	, and a , a , a , a , a , a , a , a , a , a		Betwee	en Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)		erotic Cardiov		ease					<u> </u>			
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	iner	if any, leading to immediate cause. Enter Underlying Cause		a consequence o	of):									
+	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
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be excession	edical	UNPENDED	AMENDED											
Box 68760, e death certificate b the attending physical for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the		, outcome of preg birth		tal death	3	Ectopic p	pregnanc	y	23d. Date of de Month	elivery Day	Year	
x 68 h certi tendin use a	icia	past 12 months?	4 Preg	nant at time of de	noth —	her (Specil								
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Accords, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	by F	Part II. Other significant condit	ions contributing	to death but not r	esulting in the t	inderlying c	ause giv	elilirali	L I.		2 No 3	_	_	
ls, F quires en sig uld be	ted									24a. Was a	in 24b. We	ere autopsy findi	ings available	
tal Records cian: The law requi certificate has been ector, page 2 should	ompleted						-			autops perfor		or to completion ath?	of cause of	
	S					~	Disease	4 D N- /C	Oh a ala am		2 ✓ No 1	Yes	2 No	
ital ician: s certi irector	æ	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpatient		- 10	f Death (C			Residence 6	Other: Scene		
n of Vital I ling Physician: After this certifi	<u>د</u>	1 ✔ Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time of I			at Work?			ow injury occurred			
on on ending ath.	ţi	1 Natural 5 Pen	ding	th, Day, Year)			1 Ye	s 2 1	No					
Division of Vital Records, tal or Attending Physician: The law require as after dealh. al Director: After this certificate has been si lled in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	ertification:		stigation 28e. Pla	ce of Injury - At h	ome, farm, stree	et, factory,	office bui	ilding, etc.	. 28	Bf. Location (S or Town, St	treet and Number	or Rural Route	Number, City	
Divi Hospital or 24 hours afte Funeral Dir tely filled in	Cert	4 Homicide dete	rmined (Specify)										
Hos 24 h Fun etely	Sa ((Ondon only)	hysician: To the be	est of my knowled	dge, death occur	red at the t	ime, date	and plac	ce, and du	ue to the cause	e(s) and manner a	s stated.)	
To the within To the comple	Medi	and manner stated.												
	2	D. A.R. MI	11 111				O.C.M				September 1		,	
1-1		30. Name and address of person	who completed car	use of death (Iten	n 23a)									
(+1		Pamela E. Southall, N		t Medical Exa		1 Penn S	Street,	Baltimo	ore, ME	21201				
3	tate	31. Date filed (Months 1997), Year	32. F	gistrar's Signat	ure	- 4 4								
Regis	trar	JET A:	\$ 2000 /	Broom	/3. NO.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 18, Physician/ Ž010 Charles Irving Brown 10:15P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗌 Months Hours 7/4/1926 Country) 84 Maryland **Director** 216-22-3458 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland ral", or Items 23a or 28a-f sho Examiner must be notified at Director Arnold Maryland Anne Arundel 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 1463 Grandview Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?
1 □XYes 2 □ No Black, White, etc. δ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 K No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Credit Manager Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Miller be Irving H. Brown permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl A. Brown - Wife 1463 Grandview Rd, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Baltimore Crematory 9/21/2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 1855 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar DHMH 17 Rev 7/2009

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State

29b. Signature and title of certifier

SEP 2 0 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

clae

82. Registrar's Signature

29c. License number

21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 2010 Barbara Lee Becker 8:02 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4918 Water Grove Lane Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 D M 2 D Days Min Aug 13, 1933 Months Hours 216-58-5507 Mary land 77 Vrs Director Usual Residence of Decedent shov or 28a-f show notified at 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral 4918 Water Grove Lane 21043 USA 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural" Completed 3 Widowed 4 X Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Human Resources Verizon Ith and Mental Hygie 27 is marked other raumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony Marino Katherine Podraza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Eric Becker 4037 Chariots Flight Way Ellicott City, MD 21042 son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \square Burial 2X Cremation 3 \square Removal from State 9/22/2010 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Harry H. Witzke Funeral Home Inc. Signature of Funeral Service Libensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stase IV Physician/ CARLES 2023 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate factors. Filler to serily the Examine Due to (or as a consequence of) has been signed by the attending physician and je 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home Certificate: To 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30573 OFF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charter Dr. Ste Gozo

State Registrar

10710

Minfor

31. Date filed (Month

MD

32. Registrar's Signature

Baltimore, Maryland 21215-0036

attending physician Box 68760 P.O. Records, certificate Division of Vital After

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>010</u> Month **Physician** 12:46 PM 16, Lowell Elsworth Brown Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 717 Booth Street Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, 6. Sex **Funeral** Months Days Hours 1 XM 2 □ F 214-42-8598 66 Maryland Director 16, 1944 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 717 Booth Street 21801 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, If a Medical Examinationer. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 Peb 18 If Yes, Give 15 Feb. Year or Dates: 16, 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify. Specify: Black 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mcdonnell - Douglas Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Logistics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Robert O. Brown Lillie B. Pinder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mechelle B. Vaughn/ Daughter 1508 Big Leaf Drive - Charlotte, NC 28262 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09/25/2010 Riverside, CA 4 ☐ Donation 5 ☐ Other (Specify) Riverside Memorial Park 22. Name and Address of Facility Salisbury, Maryland 21. Signature of Funeral Service Licenses Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Approximate Interval Between Onset and Death the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final disease or condition resulting in death) FIBRILLATION I ENTRIC Due to (or as a consequence of): CARDIOMYOPATHY Cotenuic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine INFARCTION the Hospital or Attending Physician: The law requires that the death certificate be executed MYOCARDIAL Due to (or as a consequence of) ATTOROS CUFFO SICS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **D** No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 \sum Nursing Home 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1. Accident within 24 hours after death.

To the Funeral Director: A 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my anisian death are used. Certific Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec one b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUSBULY SHORE DRIYE 100 EASTERN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 17, Daniel Frederick Brown ^v2010 11:20 💆 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico 7324 Cherry Walk Road Hebron . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 M 2 D F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours 79 220-26-4126 Director 2/13/1930 Delaware Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ื No Wicomico Maryland Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7324 Cherry Walk Road 21830 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates. Army 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wildfowl artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Daniel Brown Helen Cobb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7324 Cherry Walk Rd., Hebron, MD 21830 Margaret A. Brown/spouse 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 9/20/2010 Salisbury Crematory Donation 5 ☐ Other (Specify) Salisbury, MD 21. Sign sture of Funeral Service Licensee 22HOT10Way Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Wompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a sequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 4b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has performed Yes 2.2 certificate 1 Yes 2 No of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 1 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun Vatural Division 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To be best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 9 1-500

Registrar

State

5180

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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9

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 0500 A Louise C. Bruhnke September 17,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Adamstown

Vear | If Under 24 Hrs. Buckingham's Choice Frederick If Linder 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 9, 109-26-6433 77 Nov. New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ■ No Director 28a-f Maryland Frederick Adamstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 "natural", or items 23a 21710 3200 Bakers Circle U.S.A. Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: Specify. ò 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If item 27 is marked any injury or other trainment. Joseph Brings Emma Schube Brings ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Bruhnke/ Son 42565 Lovettsville Rd., Lovettsville, VA 20180 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematorium Inc. 20c. Location - City or Town, State 20a. Method of Disposition Date September 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 18, 2010 Alexandria, Virginia Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home 21. Signature of Fundral Service Licen 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-trans Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the SS IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) the 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan page 2 certificate has 1 □Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this Certification: To funeral (28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

DHMH 17 Rev 1/2001

State Registrar 29a, Certifier

29b. Signature and litle of certified

31. Date filed (Month, Day, Year)

vette Waltren

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3000-D

32. Registrar's Signature

MD

Medical

29c. License number

D0058726

Myersville mo 21773.

29d. Date signed (Month, Day, Year)

-17-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:07 P September 17ey 2010 Year Physician/ Butler Mary Jo Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Prince George's 7019 Whitney Avenue Forestville 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Months Hours Min (Month, Day, Y 2/4/1935 West Virginia 1 M 2 M F 74 Director 234-50-5027 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10c. City, Town or Location 10d Inside City Limits 10a, State Director 1 Yes 2 K XNo Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 USA 7019 Whitney Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 🛪 No If Yes, Give 1 Never Married 2 Married Completed by 1 ☐ Yes 2XXNo Specify. Specify: White ¾¼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sullivan Allie Notter Charles С. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11851 Summer Oak Drive Germantown, MD Dorothy Butler / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Md. Veterans Cem. Sept. 23,201Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA I Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ilated Physician/ Cardio MTO disease or condition Medical resulting in death) Examiner year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Vage the attending physician and hed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical year ! or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 🔀 No After this certificate has been signed by the a funeral director, page 2 should be detached 1 ☐ Yes 2 D 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 KKN Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5XX Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? nours after death. neral Director; After the filled in by the funeral Certificate: 28d. Describe how injury occurred injury 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital 24 hours a To the Hospital
within 24 hours a
To the Funeral C
completed filled Medical 29a. Certifier া 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 0004204 Name and address of person who completed cause of death (Item 23a) (Type, Print) 14314 Old Marlboro Pile flain 6- Champdovy MD- Pph Mantbovo -

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** hevin 12:08 AM Denibe 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🕅 M 2 □ F Yrs 578-76-0547 Director 54 4/26/1956 Washington, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified at Director 1 X Yes 2 No MD Calvert Broomes Island 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? 8525 Sunset Lane, PO Box 299 20615 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🕱 No Specify. ģ Specify: 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) other than Construction Sheet Metal Worker Construction or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ? Paul A. Batson ပ Patricia A. Rice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau Carla D. Batson / Wife 8525 Sunset Lane, Broomes Island, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 9/22/10 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** raumati disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence bi) The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): CERTIFICATION AS PROVED BY MEDICAL EXAMINER Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has but irector, page 2 s autopsy performed? 2 No Ýes 1 TYes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗌 No 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 Yes 2 Accident 3 Suicide ours after death. eral Director: Af filled in by the fu September 14,2010 08:30 AM 2 No tell 10ft off looker 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Towns Hospital Moderation Site | Wolfe St at Orleans St. F. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wolfe St at Orleans St. Baltimore 24 hours Funeral 29a. Certifier (check only Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State Registrar

31. Date filed (Month, Day, 32. Registra 's Signature SEP 2 2 2010

ana

eme

completed cause of death (Item 23a) (Type, Print)

of certifier

29b. Signature and

30. Name

within 2

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Soplember 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month : 45 am llenette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Joseph Ritchey Hospice If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Jan. 1923 87 Director 071-26-5363 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified and once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2K No Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral TISA 8104 Irwell Court 20877 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Native American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Rollinson Sydney Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 Trwell Court, Gaithersburg, MD 20877 Herbert L. Lehmann/Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Union Cemetery 1 St Burial 2 Cremation 3 Removal from State Sept. 22, Burtonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Sign tule of Funeral Service Lice 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, who cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in rediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for sels consequence on attending physician an for use as the transfer Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Month Day Year 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes 2 🗌 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 🖳 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 2 Medical Examiner: On the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 400104210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

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Willeneth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09/1⁰9/2010^{ear} 1800 p M Bradley Wayne Bean Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Calvert Examiner 4b. City, Town, or Location of Death 3185 Jones Road Dunkirk Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 NT TT **Funeral** Hours Min 1**x**⋅xM 2 □ F 002-42-5743 0790471959 Director 51 N.H. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Calvert Dunkirk 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3185 Jones Road 20754 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married 1 Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired)
Chief of Aeronautical
Engineering College (1-4 or 5+) Elementary/Seconday (0-12) Coast Unites States Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elsa Leone Lyons Lawrence Carl Bean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cereto Jones Bean/Wife 3185 Jones Road, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🛣 Removal from State Oak Grove Cemetery 09/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Americus, GA 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 Lisa M. Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ METASTATIC PAN CREATIC CAN CER disease or condition YSA-R Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performe 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 은 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title 29d. Date signed (Month, Day, Year) MS 1 064931 SEPTEMBER, 20, 2010 KN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BAVIS COSGREYE, 600 NORTH WOLFE SMEET, BALTIMORE, MD 21287

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

SEP 2 1 2010

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 2010 THOMAS BOONE 10:30P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAY RIDGE HEALTH CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 214-42-2837 JAN 14, 1945 65 MARYLAND **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 XYes 2 ☐ No PRINCE GEORGE'S CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 USA 4905 VEINEA DRIVE 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental ဂ္ **LEROY** SATAWHITE BERNICE BOONE and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN HAMILTON/SON other <u> 107 MARBURY COURT DISTRICT HEIGHTS.MARYLAND 20747</u> 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 X Burial 2 ☐ Cremation 3 ☐ Removal RESURRECTION CEMETERY 9/20/2010 4 Donation 5 Other (Specify) CLINTON, MARYLAND J.B. JENKINS FUNERAL HOME INC. 21. Significant of Funeral er de Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \checkmark Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an was autopsy performed? 2 **X**No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🔲 Yes 2 XNo Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 🔽 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of ceftifie

31. Date filed (Month, Day

AJIT KURUP M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1835 UNIVERSITY BLVD E. #

006368

208 HYATTSVILLE, MARYLAND

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			For State Registrar	te of Maryla		oartment of H e <i>rtificate of L</i>			giene Reg. No.? []	0 31268			
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death			
橡	Physicia /Medic		Barbara B.		B1ou	T			er 15, 20	010 2:30 P ^M			
	Examin	er	4a. Facility Name (If not institution, give street a 7517 Alfred Drive	nd number)		4b. City, Town, or Silver S	Location of Death		4c. County of				
0.00	Funeral	sta:	Social Security Number 6. Sex		rs. last birthda	y) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or F Country)				
	Director	G .	008-24-4180 1□ M 2	78	Yrs.	Months Days	Hours Will.	1-31-19	32 Wa	ashington, DC			
	land ow It		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits			
	Mary a-f sho ified a	ţċ	MD Montgomery	Si	lver S	oring				1 X Yes 2 □ No			
	or 28,	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?			
	ath w	rall	7517 Alfred Drive			20910		7 17	United S	States American Indian,			
920	be filed within 72 hours after death with the Maryland ttal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event,	by Funeral	1 Never Married 2 Married 1 If Y	s Decedent Ever ir ned Forces?]Yes 2[XNo es, Give ar or Dates:	10.8.	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes of No Rican, etc.)	Specify: 1	White, etc.			
2	72 hc "natur	eted	15. Decedent's Education (Specify only highest grade comp	leted)	(Gi	cedent's Usual Occup ve kind of work done of DO NOT use retired	during most of work	king	16b. Kind of Busin	ness/Industry			
121	within iene. than the Me	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+) 5+		Gocial Worker			Private				
פַ	0 = 0 2	Be C	17. Father's Name (First, Middle, Last)		1			e (First, Middle,	Maiden Surname)				
<u>ylar</u>	2 should be filed w n and Mental Hygie is marked other raumatic event, th	2	William Boyd				Antha Fa						
, Maryland 21215-0036	and 2 sho ealth and n 27 is m	J	19a. Informant's Name/Relationship (Type. Prioyce E. Rucker (Daught	er)	123	alling Address (Street and D4 Manship	Lane Bo	owie, MI)				
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic es once.		20a. Method of Disposition 1 ☐ Bunal 2 【☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State	cemetery, c	position (Name of rematory or other place of the coln Crematory or other place of the coll Crematory or other place of the coln Crematory or other place of the coll Crematory or other place of the	atory 9/2			, MD			
Bait	permit. Departs Imports any Inj once,		21. Signature of Funeral Service Licensee			22. Name and Addres			oln Funera ntwood, M				
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final		eath. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory a		Approximate Interval Between Onset and Death			
	/Medical Examiner		resulting in death)	Oue to (or as a cons	sequence of):	Cardiovas	cular Dis	ease					
1	LXammer	ja l	Sequentially list conditions, if any leading to immediate	ype II D:		3							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ypertens	ion								
Ó,	ficate be executed physician and is the burial-transit			Oue to (or as a cons	sequence of):		-						
68760,	cate b	edical	d										
P.O. Box 6	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	es, outcome pf pre Live birth 2 F Pregnant at time of Unknown	/		23d. Date of Month	*					
a. Di	ires that signed by be deta	by Ph	Part II. Other significant conditions contributi	ng to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?			
ğ	w require been sig should b		Hyperlipedemia					1 🗆 '	Yes 2 No 3	☐ Probably 4 ☐ Unknown			
Vital Records,	sician: The law r certificate has be irector, page 2 sh	Completed						24a. Was autop perfo	psy prio prmed? dea	ere autopsy findings available or to completion of cause of ath? I Yes 2 □ No			
<u>Ia</u>	clan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea						
0	Physic this c	၉	1 ☐ Yes 2X No Hospita	l: 1 ☐ Inpatient 2	2 ER/Outpat		4 LI Nuising n		dence 6 Other	(Specify)			
o	ding h. h. After funer	tion:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year		y Wor	ryat rk? Yes 2 ∐ No	280. Describe	how injury occurred				
Division or	al or Atter after deal Il Director d in by the	Certification:	2 ☐ Accident	Place of injury - A building, etc. (Sp.		street, factory, office				or Rural Route Number,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: O ar										
)	To the within To the company company	Ž	29b. Signature and title of certifier Allow Loo Loo Loo Loo Loo Loo Loo	fozed		29c. Licens MD 1			29d. Date signed (
R	_10	D	30. Name and address of person who completer. Abbas Motazedi 1150			Suite 111	Washing	gton, DC	20017				
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 2010	32. Registrar's Si	gnature	/							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 Physician/ Rosemary Theresa Boes 7 2010 3:53 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 Months nth, Day, Year) 166-34-5908 **Director** 69 PA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗆 Yes 2 😾 No Montgomery Chevy Chase 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5480 Wisconcin Ave., Apt.1228 20815 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White "natural" 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Leasing Senior Lease Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Charles Boes Pauline Conrad and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Judith Culley 13417 CarrageenDr., Manassas, VA 20112-3838 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō <u>=</u> Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Potomac Crematory 9-10-10 Dale City, VA 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fineral Service Licensee 22. Name and Address of Facility A Dignified Funeral & Cremation 18493 Running Pine Ct., Triangle, VA 22172 92 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗷 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 \square Pending work? 1 ☐ Yes 2 ☐ No injury 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address

31. Date filed (

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to

6410 Rockledge Dr., Sute 200, Bethesda, Maryland 20817

of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09 Month Physician/ 2010 Thomas Enoch Campbell 3:46aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Country). VA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 1 M M 2 □ F . Age (In yrs. last birthday) **Funeral** Days Min. Hours 10^{(Month} Day, 1936 Director 230-42-6892 73 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ems 23a or 28a-f sho must be notified at Director 1 🕅 Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4211 Nash Street S.E. 20020 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò Completed by 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates. 7/60 7/66 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 at Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electrician **Federal** Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o မ Paul P. Campbell Mary Ella Cabbell 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette M. Campbell/ Wife 4211 Nash Street S.E. Washington, DC 20020 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Ft. Lincoln Cemetery | 09/24/2010 | Brentwood, MD 4 Donation 5 Donation 5 Other (Specify) al Service 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD_20722 23a. Part 1 Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine If any, leading to in mediate cause. Enter Underlying POTENSION as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Pregnant at time of death 5 Other (specify) Day Year the Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و ک Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29d. Date signed (Month, Day, Year) 2010 erson who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year,

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32. Registrar's Sign

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:35 Рм Eloise G. Carpenter September 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince Georges Prince Georges County Hospital Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Sept. 13, 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🗓 F Min. 1946 โซซีซีกois Director 322-40-7691 64 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Pricne Georges Riverdale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20737 USA 5903 Eastpine Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. and Mental Hygiene. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CPA United Health Care 8+ permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gaynell F. Rice Hugh H. Maurer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5903 Eastpine Drive Riverdale, MD 20737 Patrick Carpenter/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 9/25/2010 | Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner LGL Leukemia/ Neutropenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated separate in the conditions of th To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been shown that the death of the property of Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 Mo
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Rheumatoid Arthritis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Division of Vital completed filled in by the funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury work? 1 ☐ Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0043361 9/17/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2150 Pennsylvania Avenue NW Suite1-100, Washington, DC 20037 M.D. Robert Siegel, 31. Date filed (Month 2. Registrar's Sign

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Sharon Mills Cohen 4:45 PMSeptember 20, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days Hours Min. 578-56-2509 68 September 9, 1942 Washington, Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marked Examinar must be retitled at once. 1⊠Yes 2 No Director Prince George's Mount Rainier Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20712 USA 4503 32nd Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Budget and Fiscal Analyst Department of Justice 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Mills Elvy Kjorness 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michelle Ann Cohen / Daughter 4503 32nd Street, Mount Rainier, MD 20712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 9/21/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 11110 MINEN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OBSTEUCIVE PULMONARY DISEASE Immediate Cause (Final disease or condition resulting in death) CHRONIC **Physician** /Medical Due to (or as a consequence of): OBSTRUCTIVE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine MORBID OBESITY To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 MERLITUS DIABETES Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> HYPERTENSION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 L Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tive of certifier 29c. License number AAMUM, 4D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK, MD-20012 WASHINGTON ADVENTIST HOSP., SHAHID SHAMIMIMD 31. Date filed (Month, Day, Year SFP 2 2 2010 32. Registar's Signature State Registrar

For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>0 2010</u> Physician/ CHASE SEPTEMBER 3:32 A M ETHEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S BOWIE LARKIN CHASE NURSING HOME Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1934 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) OCTPBER 1. Days Hours 1 M 2 X F Months Min. NORTH CAROLINA Yrs **Director** <u>243-50-0544</u> Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland al Hygiene. "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No NC EDGE COMBE ROCKY MOUNT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27801 USA 1716 CHARTER DRIVE Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or 1 ☐ Yes 2 🗓 No If Yes, Give Completed by 1 Never Married 2 X Married Maryland 21215-0036 BLACK 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manan injury or other traumatic event the Manan Elementary/Seconday (0-12) College (1-4 or 5+) NURSE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES BATTLE MINNIE MANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $12008\ THACKERAY\ COURT\ BOWIE, MARYLAND\ 20720$ JOYCE GREENFIELD/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HARMONY CEMETERY 9/24/2010 LANDOVER, MARYLAND J. B. JENKINS FUNERAL HOME, INC. . Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PANCYTOPENIA Medical Due to (or as a consequence of) Examiner SEVERE AMENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit CHRONIC LYMPHOCYTIC LUKEMIA Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical PNEUMONIA as SP 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?

1 Yes 24 No for Month Day Year Pregnant at time of death signed by the a 1 Yes 24 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🛣 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. of Vital completed filled in by the funeral Division hours after death. To the Hospital o within 24 hours af To the Funeral Di

State Registrar

Medical

29a. Certifier

2 L 3 L

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OKEOWO IBITOYE M.D. 12200 ANNAPOLIS ROAD # 232 GLENNDALE, MARYLAND

31. Date filed (Month, Day, Year 32. Registrar's Signature SEP 2 2 2010

determined

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D51437

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) SEPTEMBER 20, 2010

20769

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dickson Carolyn L. 2010 A^{M} 7:10 September Medical 4b. City, Town, or Location of Death **Silver Spring** 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery **Examiner** Holy Cross Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 97 Days Hours Min 1 M 2 👿 F Months 306-48-3295 Director Yrs Indianapolis, IN Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 □ No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20910 1900 Lyttonsville Road Unit 715 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ğ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: **Black** If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Medical Physician should be filed w and Mental Hygi is marked othe event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name_(First, Middle, Maiden Surname) Heston ပ Carrie Clarence Lucus permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. · traumatic 19a. Informant's Name/Relationship (Type, Print)
Leon Ashby Dickson, Jr./ Son 1900 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 Lyttonsviile Road Unit 715 Silver Spring 1100 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 9/22/2010 | Brentwood, MD 21. Signature of Funer Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Physician Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Yrs End-Stage Dementia Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown Day g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Cachexia, Prior CVA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 🗌 Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 10 Other: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral (27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 9/19/2010 D 0065485 ouparisch RSM MD

State Registrar 1500 Forest Glen Rd.

Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Supanich, MD
31, Date filed (Month, Day, Year)

SEP 2 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For AMEND#8 per FH State Registra(AAC) HEALTH DEP	State of Maryla	-			ealth a Death	ind Me		giene2 () Reg. No.	0	312	75	
			1. Decedent's Name (First, Middle, Last)	. GH 5/20/10						2. Date of Dea Month		Year	3. Time of E	Death	
	Physici /Medio		Elizabeth Perr	y Dees							ber 16,		11:3	OA M	
	Examir		4a. Facility Name (If not institution, give s.					Location of	f Death		4c. County		-		
			Spa Creek Nursing				nnap		14 Hen	(2)		Arund			
	Funeral Director		010 22 0750	7. Age (In yrs	s. last birthday) Yrs.	Months	Days	If Under 2 Hours	Min,	B. Date of Birth (Month, Day 2/23/2	n2/23/192 /, Year) 010	99. Birthpl Count Conn	ace (State or try) ecticu	Foreign	
	pu *		Usual Residence of Decedent 10a, State 10b, County	100.0	City, Town or Lo	cation						10	d. Inside City	Limits	
	e-f sho	ctor	Maryland Anne Aru		nnapo1								1 X Yes		
	h with th	al Director	10e. Street and Number 15 Sil	opanna		10f. Zip	Code	2140	03		10g. Citizen of	What Coun	us?	A	
9036	72 hours after death with the Maryland natural', or Itams 23e or 28e-f show Jeal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		ce - America ck, White, e fy: Whi	etc.		
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Maryland	nd 2 should ith and Men 27 is marka traumatic	-	19a. Informant's Name/Relationship (Typ. William J. Dees		r, City or Town		Code)								
	itam 27		20a. Method of Disposition		Place of Dispo	sition (Na	me of	-1	Da	-	20c. Location		wn, State	-	
E	0 0	h	1XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ariangton National Cem 10/29/2010 Arlington, VA 22. Name and Address of Facility John M. Taylor Funeral Home												
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		22	2. Name a	nd Addres	s of Facility	y Joh	ın M. T	aylor F	unera	1 Home		
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J.	Pnysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the de-	ath. Do not ent	er the mod	de of dyin	g, such as c	cardiac or	respiratory ar	rest,		Approximate Interval Betw Onset and Do	een	
8760,	Examine be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	qu. nce of):	ter En t	Les des	rsea only	ni Lone	, P	lisear	e	yea wee	N hs/ N	
.O. Box 6	at the death certific by the attending p tached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic p □ Other (s)						ate of delive onth	*	ear	
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of Vital Records,												prior to con death?	osy findings a npletion of cal	vailable use of	
Vite	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Oth	25		(Check only o					
n of	Phys this al di	on: To	1 Yes 2 Do	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	To be designed to the last	OA Othe 28c. Injun Work	41,8000			lence 6 □Ot now injury occu		")		
Division	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	1				Yes 2□N		Bf. Location (S City or Tow	Street and Num m, State)	ber or Rura	l Route Numb	<i>9</i> ⊖ <i>r</i> ,	
marked?	e Hospital 24 hours e Funaral letely filled	edical Co	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	cian: To the best of my keer: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, ar th occurre	nd due to the o	cause(s) and m	nanner as st , and due to	ated. the cause(s)		
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and states.		29	c. License	e number			29d. Date sign				
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	gu.		30. Nam and Iddress of person who cor	npleted cause of death (Ite	em 23a) (Type,	Print) I	_	T. I	Davi	S	9/1	101			
	Sta	to	31. Date filed Company Asset Control	32. Registrar's Sign	nature 4	-14	, 147	MAP	ULIS	, mi	214	0/			
	Sta Registr		SEP 2 0 2010	Dengue &	. par	Kel									

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. Amend Item 21 per FH G908 10/6/10 dk. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 4:00 AM September 28,2010 Gladys Doyle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Lions Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 1919 Terre Haute, IN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 □ M 2 🔀 F 311-16-1576 29 Director 90 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director PA Franklin Greencastle 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17225 US 2310 Pikeside Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐Yes 2 No white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fed. Government budget analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Doyle Agnes Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. Doris L. Brooke/friend Box 495 Ridgeley WV 26753 Route 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chestnut Grove Cemet. 10/1/2010 | Herndon, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Bowersox Funeral Home 21. Signature of Funeral Service Licensee James A. Bowersox per DVR 521 S. Washington St. Greencastle, PA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE CELEBRO VACULAR
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1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) o. 1 ☐ Yes 2 Dolo been signed by the should be detached 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 □ Yes 2 🔊 No certificate 2 **X**No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D002690-September 28,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Road, Cumberland, MD 21502 Sidhu MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month, Kose 3:20 P.M peptember 29 2010 Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Healthcare of Hagerstown Washing ton Hagerstown Birthplace (State or Foreign Country) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min. Months 1 □ M 2 🔀 F 052-16-9103 December 18, 1420 Director rennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Washington Hagerstown ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Marsh Pite 21742 14014 U-J-A-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. Homemuter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Borac Mun 1an 1a K 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 Is boonshore MD 21713 Arcadia Lane 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory 1 Burial 2 □ Cremation 3 Removal from State Wergreen Lemeten 2010 4 Donation 5 Other (Specify) 22. Name and Addre 21. Signature of Funeral Service License Cornisle Street Getty buy Pa 17325 23a. Párt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Appro in ate Interval etween Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician **Medical ≝**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death the by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 autopsy page 2 performed? res 2 No this certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Injury 5 Pending investigation 1-⊟Natural 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) auletan Tall 1 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 25 per me, g908, 10/08/2010dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jonth Physician/ ORVILLE DIEHL JOSEPH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL MED, CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Cumberland ANEGAN 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 🗷 M 2 🗆 F 220-16-5687 84 **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiera 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MOUNT SAVAGE ALLEGANY MD1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? FOUNDRY ROW NW Funeral 21545 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 43-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER TRUCKING-COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FRANK LUla Ann MichaElS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15947 FOUNDRY ROWNW MT SAVAGE MO TODD A DIEHL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🖼 Removal from State 9-21-2010 FLINTSTONE ROCKY GAP VA CEM. 4 Donation 5 Other (Specify) 22. Name and Address of Facility HARVEY H. ZEIGLER 21. Signature of Funeral Service Licensee 169 CLARENCE ST HYNDMAN PA 15543 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ြု 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifier 29c. License numbe ပ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 Willowbrock RO Comberland MO MO SUITE 440 RAMAR ZAMAN

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year) SEP 23

32. Redistrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 Elsie Paige Doleman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year) Jan. 15, 1915 If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 ☐ M 2 😿 F Days Min 95 Director 220-42-5507 Virgińia Usual Residence of Deceden items 23a or 28a-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 ☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 644 Pennsylvania Ave. USA 21740 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 K Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Specify: Black Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 th Public Schools Cafateria Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ John H. Jackson Emma Virginia 19a. înformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isaac C. Doleman / Husband 644 Pennsylvania Ave., Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedarlawn Memorial Park 109/24/2010 | Hagerstown, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician mujor disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 24lous Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a cor attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perfor To the Funeral Director: After this certificate is completed filled in by the funeral director, page 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2√ No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 \square Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(3 \square Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifie 29d. Date signed (Month, Day, Year) 22-10 365 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Da

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 18, Day 2010 George Elliott 9:58 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X XM 2 F 142/2971924 Washington, DC 579-26-7172 85 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Maryland Prince George's 1 Yes 2x No Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2204 Piermont Drive 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2XX No Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White 3 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Small Business Admin. 12 years Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Ε. Elliott Blanche T. Morris Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Elliott / Son P.O. Box 135 Chesapeake Beach, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Resurrection Cemetery 09/22/2010 Clinton, Maryland 4 Donation 5 Other (Specify) Funeral Service Ligens 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mar Medical resulting in death) Due to (or as a cons pence of) **Examiner** Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ig physician and as the burial-transit Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Tes 2 No 25. Was case referred o medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 V No 1 Malient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1- 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 68049 2010 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll Ave 7600

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Durst Funeral Home, 57 Frost Ave., FrostDurg, MD 27532 23a, Part. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory or other place) Cremation 5 ☐ Other (Specify) Cremation 5 ☐ O												/lvania		
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Due to (or as a consequence of): Cause (Disease or injury resulting in death) Last		Interval Betwoen the Cause (Final disease or condition resulting in death) a. A theres developed the Cause (Tinal disease or condition resulting in death)													
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didness of person who completed cause of death (Item 23a) (Type, Print) 29a. Certifier (Check only one) 29b. Signature and due to the cause(s) and manner as stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of in (Month, D	njury 28b. T	Time of	28c. Inj	iry at rk?					ony)			
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sep 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	al Certif		28e. Place of It		rm, stre	et, factory, offic					umber or Ru	ıral Route Nur	nber,		
Wonseels Shiri MD 80055325 Sep 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Medica	(Check 2 Medical Exa	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man									cause(s) and r	nanner state		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			f Shu	· MS)					_					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2012 56 M Frederick Carlton Ernst Jr. Seckember 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 13644 Broadfording Road Clear Spring, Washington f Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 - 20 - 1939 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** MD Months Days Hours Min **T**✓ M 2 □ F 220-42-7304 Director Usual Residence of Decedent 10c City, Town or Location Clear Spring 10a. State 10b. County 10d. Inside City Limits ra!", or items 23a or 28a-f show Exarcher a ust be notified at MD Washington 1 ☐Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 21722 U.S.A. 13644 Broadfording Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Exambles 1, unto ponce. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) farming Elementary/Secondary (0-12) College (1-4or 5+) farmer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Carlton Ernst Sr. Ora Ann Bussard 2 19a. Informant's Name/Relationship (Type. Print)
Arnita Ernst wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13644 Broadfording Rd.Clear Spring, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St Paul Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 9-24ª Clear Spring, 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| Description | P.O.BOX 310 Clear Spring, MD 21722 | Approximate shock, or heart failure. List only one cause on each line. Kaitlen Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Renal Ce11 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial use as t F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No 1 ☐Yes 2 ☑No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 TYes 2 7No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death. Ieral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

OF US

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael MCO/Macle (1110)

4166

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31283 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Ever 11 Joan W. 20 2010 3:44 A M /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Mt Airy 713 Midway Avenue Mt Airy Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 89 Director 214-36-9936 10/17/1920 Argentina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show at MD Carrol1 mit. Pages 1 and 2 should be filed within 72 hours after death with the Mary sartment of Health and Mental Hygiene. sortment of Health and Mental Hygiene. sortant: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified. Mt Airy Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21771 United States 2880 Sommersby Road Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Herbert Gregory Dorothy Lomax ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virgnia Kunkel - daughter 2880 Sommersby Road Mt Airy MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 8/23/2010 | Marriottsville MD Crest Lawn Mem. Gard. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry Witzke's Family FH Inc 21. Signature of Funeral Service Licensee M01044 Sherri Collins-Witzke per DVR 4112 Old Columbia Pike, Ellicott City MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 /Medical ue to (or as a conseque do of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner us to for as a consequence off executed and buriat-tran Due to (or as a consequence of): P.O. Box 68760 physician certificate be Physician/Medical the as attending I IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 Other (specify) the detached a∏tJnknown 9 Unknown ģ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 be 1 Yes No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2**70** No 2 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Nurse Practitioner 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person with

OCT 0

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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× 68 th certi	iciai	past 12 months	?	4 Pregna	nt at time o	of death 5	Fetal de	eath 3 (S <i>pecify</i>)	Ectopic p	regnancy		Month	Da	ay Year
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	G	(Check only	ertifying Phy ledical Exam	sician: To the best iner:On the basis of	of my know examinatio	ledge, death	occurred at	the time, da	ite and place,	and due to	the cause(s) and manner a	s stated	
To the within To the Compl	Med	29b. Signature and ti		and manner sta	ted			29c. License				29d. Date signed		
IVn		hi	hi	, vi				O.C.N				September 2		
- 44	-	30. Name and addres	ss of person w	ho completed cause	of death (I	tem 23a)				<u> </u>		,		
•		Ling Li, MD	Assistan	Medical Exam		11 Penn S	Street, Ba	altimore, I	MD 21201					
Sta	ite	31. Date filed (Month,	Day, Year)	32. Regi	strar's Sigr	nature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Fatiadi Alexander J. 10:00p Medical Sept 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hill Haven Nursing Adelphi If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Min. Hours 577-48-1424 87 1072271922 UKraine Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Burtonsville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15113 Briarcliff Manor Way Funeral 20866 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Research Chemist N.I.S.T. perfait. Page 1 and 2 should be filed with Det artment of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Johann Fatiadi Gondarchenko Maria 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20866 19a. Informant's Name/Relationship (Type, Print) Tamara A.Stoner/Daughter 15113 Briarcliff Manor Way Burtonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rock Creek Cem. 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/22/2010 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o PHYTTP ADD STINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2 min shock, or heart failure. List only one cause on each line Immediate Cause (Final Cardiac arrest Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Cardiac arrythmia 15yrs Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Coronary artery disease sician and burial-transit 25yrs Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hypertension that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ atrial fibrillation, cva, anemia, dysphagia, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Records, Completed azotemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 XN Hospital or Attending Physician: The 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 🗌 Pending injury death. after death

Director: A

d in by the fi ☐ Accident ☐ Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in I within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier 1 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tholi D17843 Sept.20,2010 can who combleted cause of death (Item 23a) (Type, Print) 3311 TOLEDO TERRATE

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

68760

Box

P.O.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		Please	Type or Pri								•	•		
	•	For State Registrar	State of Ma	arylan		partment of ertificate of			Mental Hygiene Reg. No. 2010 31286					
Physicia Medic		Decedent's Name (First, Middle, La. Do	^{st)} nna <i>Jear</i>	2	Furl	Long			2. Date of De Septen		^{ay} 21, 201	3. Time of Death 7:10PM M		
Examine		4a. Facility Name (if not institution, give Golden Living			4b. City, Town, or Location of Death Frederick					40	Freder	ick		
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B je fe S	2	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		5. 13	3. Was Decedent of lif Yes, specify Cub 1 ☐ Yes 2 ☑ N	an, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit			
72 hour	Completed	15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					16b. l	Kind of Business	Industry			
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Id be filed Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last) Daniel Stirk					18. Mo		e (First, Middle, n Polde:		,			
nd 2 shouealth and m 27 is mer traum		19a. Informant's Name/Relationship (Information July 1997) Douglas J. Furlor		_		ailing Address (Stree Antler R								
Page 1 aunent of Hannert of Hannert of Hannert of Hannert If item	200	20a. Method of Disposition 1		C	emetery, cr	position (Name of rematory or other pla Cemetery	ice)	Sept	Date :ember 2010	I .	Town, State			
permit. Departr Importa any inju	Ì	21. Signature of Funeral Service Licens	Davis	MO 14	1 4 4	22. Name and Addr		cility	J.L. Da		Funeral	Home land 21783		
		23a. Part 1. Enter the disease, or com	plications that caused	the death							g, mary.	Approximate		
Physician/ Medical	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):											Interval Between Onset and Death		
Examiner	Ļ	HYDOKIA										DAY		
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	ı consequ	ence of):									
୍ର ଅଟ୍ର	न्न	resulting in death) Last	Due to (or as a	a consequence of):										
sertificate nding pho	n/Med	IF FEMALE: 23b. Was decedent pregnant	of pregna							23d. Date of de	liven			
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	235. Was decedent pregnant in the past 12 months? 1									Month	Day Year		
law requires that the der has been signed by the e 2 should be detached	۵	Part II. Other significant conditions c	ontributing to death bi	ut not res	ulting in the	e underlying cause g	iven in Pa	ert I.				the cause of death?		
The law rec ate has bee page 2 sho	Completed		-,,-			1)					prior to death?	topsy findings available completion of cause of		
sician: The certificate l	a	25. Was case referred to medical examiner?	Hospital:					eath (Checi		2 X 1N	0 1 10	5 2 1110		
y Physi er this c eral dir	은 6	1 Yes 2 No 27. Manner of Death	1 Inpatie	у	28b. Time	of 28c, Inju	$\overline{}$	Nursing Ho	me 5 Resi		Other (Spec	cify)		
tending death. tor: Affe the fun	Certificate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b	e ———		injury	M 1 L		□ No						
ital or Ai Ins after al Directed in by	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Location (Street and Numb City or Town, State) 28e. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and mann											ral Route Number,		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exam	sician: To the best of a Iner: On the basis of ex se Practioner: To the I	amination	and/or inve	estigation, in my opin	ion, death	occurred a	the time, date a	and place	e, and due to the	cause(s) and manner stated.		
T V V V V V V V V V V V V V V V V V V V		29b. Signatury and title of certifier				29c. Licens					ite signed (Mo <i>nti</i> otember	h, Day, Year) 22, 2010		
5		30 Name and address of person who of	10	eath (Item	23a) (Type,	Print) FOE	Den	(Ve)	20 21					
State Registra	e r	31. Date filed (Month, Day, Year)	32. Fegistra	r's Signat		have		/						
			1		-									

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Piez 1 – For State Registrar	State of M		d / Dep	ndelible in artment of F rtificate of L	lealth and			2010	31287		
Physicia Medic		1. Decedent's Name (First, Middle Margaret Cream						2. Date of De Month Septen	eath D	av Year	3. Time of Death 7:31 A M		
Examin		4a. Facility Name (if not institution Holy Cross Hos				4b. City, Town, or	Location of Dea			c. County of Dea			
Funeral		5. Social Security Number			ast birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Bir	th av. Year)	9. Bir	thplace (State or Foreign		
Director		578-74-8481 Usual Residence of Decedent	12 11 2 23 1	49	Yrs.				7 , 1	961 Was	hington, DC		
-f shovied at	Director	10a. State 10b. County Maryland Princ	ce George's		y, Town or Lo eenbel						10d. Inside City Limits 1 Yes 2 □ No		
or 28a e notif		10e. Street and Number	e deorge s	<u> </u>	eenbel	10f. Zip Code			10g. C	. Citizen of What Country?			
ms 23a must b	Funeral	7818 Hanover F					20770			USA			
", or iter	by	11. Marital Status 1 Never Married 2 Mar	If Voc Give	>		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	•	14. Race - Ame Black, Whit	e, etc.		
atural'	eted	3 Widowed 4 X Divorced	Year or Dates.			dent's Usual Occup			16h	Specify: W	hite		
hin 72 r he. han "n e Medi	Completed	(Specify only higher Elementary/Seconday (0-12)	est grade completed) College (1-4 or	5+)	(Give life. L	kind of work done o OO NOT use retired)	luring most of w	-	1.	vernment	-		
Hygier Hygier other t	Be	12 17. Father's Name (First, Middle, I	Last)		Administrative Assistant Governm 18. Mother's Name (First, Middle, Maiden Surname)						-		
Mental Alental arked atic ev	ပ	Robert Joseph	Creamer					J. Howan					
permit, Fage 1 and 2 should be lined within 72 hours aren death with the Maryland appartment of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	19a. Informant's Name/Relationship (Type, Print) Nicole D. Creamer / Sister-in-law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 3302 Tidewater Court, 01ney, MD 20832												
Jage 1 ar	2	20a. Method of Disposition 1 ☐ Burial 2 🄀 Cremation 4 ☐ Donation 5 ☐ Other (\$		e C	0b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 9/17/2010 Alexandr						Town, State Virginia		
permit. Departin Importa any inju		21. Signature of Funeral Service I	Licensee		G G	2. Name and Addres	ss of Facility	ome, P.A.	473 Hya	9 Baltin	more Avenue , MD 20781		
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	r complications that cause only one cause on each lir	ed the death	-				_	2	Approximate Interval Between		
hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Endomet Due to (or as			r					Onset and Death Years		
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ysician ar	cal	Due to (or as a consequence of): d. Peritoneal Carcinomatosis Months											
ding physe as the	/Mec	IF FEMALE:	22.5.										
requires that the dealth certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of d	Ideath 3	Cther (specify)	у			23d. Date of de Month	Day Year		
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certific rector,	æ	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				ace of Death (Ch						
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within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical E	g Physician: To the best of Examiner: On the basis of g Nurse Practioner: To the	examination	and/or inves	stigation, in my opinio	n, death occurre	d at the time, date a	and plac	e, and due to the	cause(s) and manner state		
	2	29b. Signature and title of certifier	•			29c. License				ate signed (Mont			
3		Barbara Suparich RSM, MD D 0065485 09 16 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Ann Supanich											
		1500 Forest Gl	len Road, Si	lver	Spring		10	Jupanitui					
Stat		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ure								

DHMH 17 Rev 7/2009

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		For		Sta	te of M	arylan		•		lealth and N	Mental Hy	/gien	e o o i	0	21	200	
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		1. Decedent's Nam	e (First, Middle	e, Last)							2. Date of De		211	Vaar	3. Tim	e of Death	
Physicia /Medic		VESSIE		GIVENS							Month SEPTEMI		ay 9 :	Year 2010	6:3	5 P M	
Examin		4a. Facility Name (If not institution)			4b. City, Town, or	r Location of Death	ath 4c. County of Death						
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uneral		5. Social Security N		6. Sex	7. A	ge (In yrs.	last birth	day)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi						
irector		224-38-86	661	1 □ M 2	XIF	77	Υ	rs.	Months Days	Hours Min.	8. Date of Bi (Month, D OCT • 2	2, real	1932	COU	Ne	С	
		Usual Residence o	f Decedent														
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28	Director	10e. Street and Nu	mber						10f. Zip Code			10g. C	0g. Citizen of What Country?				
33a c	a D	7520 SUI	RRATTS	RD.			20735 USA										
Su E	Funeral	11. Marital Status		12. Wa	12. Was Decedent Ever in U.S. Armed Forces 13. Was Decedent of Hispanic Orig						ecify Yes or N	0-			can Indiar	٦,	
ar ite	Ŀ	1 Never Marr	ried 2 Marr	ied 1	ned Forces Yes 2	No						ck, White,	etc.				
E al., c	þ	3 🖾 Widowed	4 Divorced	Yes	es, Give ar or Dates:			TI	□Yes 2. No	Specify:			Specify	BL.	ACK		
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ent a	Be (17. Father's Name	(First, Middle,	Last)						18. Mother's Nam	e (First, Middle	e, Maide	n Surnan	ne)			
rked	10	Uk	nown							Lou Ella	Thomas						
s ma		19a. Informant's N	ame/Relations	hip (Type. Prii	nt)					and Number or Ru							
27 is		Ella Glover/Daughter 5733 29th Ave. apt.#202 Hyattsville, Md 207											20782	2			
othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Ci									City or To	own, State	9				
7 ti		1反Burial 2□Cremation 3□Removal from State 4□Donation 5□Other (Specify) Md Veterans Cemetery 09/20/2010 Cheltenham,									ham.	Md					
Department or neath and wenter righter. Department of neath and wenter righter. By Injury or other traumatic event, the Medical Exeminer must be notified at once.					- /					• 1	•			•			
any l	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4308 Suitland Road Suitland, MD 20746																
		23a. Part 1. Enter t	the disease, or	complications	that cause	the deat	h Dono			ng, such as cardiac				Г	Approxi	mate Between	
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or us	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of deliver birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of deliver birth 2 Fetal death 3 Ectopic pregnancy									ery Day	Year						
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d by the attending physician and etached for use as the burial-transit	Physician/Medical	9 Unknown		nn contribution	a to dooth t	u 10 mat 1000	ultina in A	ha ur-	larlying sause =i-	on in Part I	230 Did	tobacco	LIEG cont	ributo to 1	the cause	of doath?	

Completed Be

Certification: To

Medical

State

Registrar

1 Yes 2 No

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 X Natural

2 Accident

3 Suicide

4 Homicide

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 至 Unknown

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of 1 ☐Yes 2 ☐No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D45565 9-15-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20744 Ft. Washington, MD Michael Sidarous, MD 11701 Livingston Rd. #101

31. Date filed (Month, Day, Year)

32. Registrar's Signature SEP 2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9-17-10 **Physician** GEORGE E. GODFREY 12:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner MANOKIN MANOR NURSING HOME PRINCESS ANNE SOMERSET If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12–24–1916 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F DELAWARE 93 221-24-3679 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County 28a-f show ral", or items 23a or 28a-f show Director 1XYes 2 □ No MARYLAND WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1630 MERCER'S WAY 21811 US Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No WHITE Specify þ 3 X Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 127 is marked other than "r r traumatic event event, the Med Elementary/Secondary (0-12) College (1-4or 5+) TECHNICIAN POULTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EVERETT S. GODFREY LAURA JUSTICE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY G. GODFREY/SON Department of Health Important: If item 27 any injury or other trong once. P.O. BOX 1935, WILMINGTON, DE. 19899-1935 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Gremation ST. GEORGE'S CEMETERY 9-22-10 CLARKSVILLE, DELAWARE 4 ☐ Donation 5 Quer (Specify) 21. Sign ture of Funer 22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD 43 THATCHER ST, FRANKFORD, DE. 23a. Part 1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCVI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-tran Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ₹ INo 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 2 No 1 ☐ Yes funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760. Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number NG/4 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUSBURY N+TETA~ Sheek 1415 5- DIVISION vel

29d. Date signed (Month, Day, Year)

21804

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State Registrar		State of Ma	aryland	d / Depa <i>Cer</i>	artment of F <i>tificate of L</i>	Health and N Death	/lental Hy	giene 2	010	31290
Physicia	in/	Decedent's Name	(First, Middle, Las	t)					2. Date of De Month		Year	3. Time of Death
Medic Examin	cal	Lai 4a. Facility Name (if I	ura Gibson	street and number)			4b City Town or	Location of Death	Sept 14	4. 2010	ounty of Death	12:25 P M
1		Southern	n Maryland	Hospital.			Clin	ton			rince Ge	_
Funeral Director		5. Social Security Nu 243 14 1582	2 1		9 (In yrs. Ia 19	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept. 7	ıy, Year)	Cou	nplace (State or Foreign ntry) h Carolina
and show Lat	ō	Usual Residence of I 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
Maryli 28a-f	Director	Maryland	Prince Ge	orge's		Clint	con					1 ☐ Yes 2XX No
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eath w tems?	Funeral	11. Marital Status	nate briv	12. Was Decedent E	ver in U.S.		2073. Vas Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-		ted Stat	
Bartimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Marrie 3 ☐ Widowed 4		Armed Forces? Ytu Yes 2 Hayes, Give Year or Dates.	No WWII		Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)		Black, White, ec <i>ify:</i> Whi	
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aryid nould b nd Mer s mark umatic		ALTY 19a. Informant's Nar	ed Guffee me/Relationship (Ty	pe, Print)		19b Mailin	ng Address (Street a	DUCLI and Number or Rura	ar Potts		un State Zin	Code)
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Saltimofe, bernit. Page 1 and Papartment of Hee mportant: If item iny injury or othe			Cremation 3 🗆	Removal from State	се	metery, crem	sition (Name of natory or other place	e)	Date /2010		tion - City or T	
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certifica nding p		IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outcome o						234	I. Date of deliv	/en/
he death or the death or the attelliched for u	Physician/M	in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown		1 Live Birth 2 4 Pregnant at 9 Unknown			Ectopic pregnanc Other (specify)	у		200	Month	Day Year
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afor death. Within 24 hours afor death. With the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other signific	cant conditions co	ntributing to death bu	it not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did to	1	_	he cause of death?
ne law requires e has been sig tge 2 should b	Completed								24a. Was autop	rmed?	prior to co death?	ppsy findings available empletion of cause of
Physician: The law this certificate has all director, page 2	Be C	25. Was case referred examiner?					26. Pla	ace of Death (Check	1 🗆 Yes	2 X No	1 Yes	2 L No
Physic this ce	은	1 Yes 2 2	(No	lospital: 1 Unpatie 28a. Date of injur		R/Outpatient		4 U Nursing Ho				()
ath. r: After	icate	1 Natural 2 Accident	5 ☐ Pending Investigation	(Month, Day,	Year)	injury	28c. Injury work? M 1	rat ? Yes 2 □ No	28d. Describe h	ow injury occ	curred	
al or Atte s after de li Directo	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injur building, etc.		ne, farm, stre	et, factory, office		28f. Location (S City or Tow		imber or Rura	l Route Number,
ne Hospit n 24 hour ne Funera pleted fille	Medical	(Check 2 L	Medical Examir	ician: To the best of ner: On the basis of exe e Practioner: To the b	amination a	and/or investi	gation, in my opinio	n, death occurred at	the time, date a	nd place, and	d due to the ca	use(s) and manner stated.
To tll within Com	4	29b. Signature and ti		luO-			29c. License	_			gned (Month,	
BESTU		30. Name and addres	ss of person who co	ompleted cause of de	ath (Item 2	23a) (Type, Pr	int)	Pr((1)	nton	md	1073	5
Stat	е	31. Date filed (Month,	Day, Year) P 2 2 201	32/Registrar	's Signatu	re	W.A			-111-12	7010	-/
Registra	II	- 01	-1 88 20	U Lesur	1 10	- Ba	un					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9/8/2010 Physician/ 11:30 A M HUNGERFORD Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death PRINCE GEORGE'S 5308 LEVERETT STREET OXON HILL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6/6/1930 1 M 2 K F Months Days Hours Min Washington DC 577-40-5243 Director 80 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location the Maryland notified at 10d. Inside City Limits Director MD PRINCE GEORGE' OXON HILL 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or 5308 LEVERETT STREET Funeral 20745 USA items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. BLACK If Yes, Give Year or Dates Specify: "natural", 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSE KEEPING PROVIDENCE HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o ပ LEROY BENJAMIN CREEK MARY FLORENE HAWKINS permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM 5311 LEVERETT STREET OXON HILL MARYLAND 20745 CREEK - DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 $\overline{\mathbf{K}}$ Burial 2 \square Cremation 3 \square Removal from State LINCOLN CEMETERY 09/17/2010 BRENTWOOD MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) ATHEROSCLEROSIS CARDIOVASCULAR DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or se a consequence of): use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown is been signed by the should be detached Part II. **Other signific**an**t conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, unter death.
al Director: After the in by the fundament. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a

To the Funeral D the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D45365 29d. Date signed (Month, Day, Year) SEPT 13 2010

State Registrar 11701 Livingston Road Fort Washington Maryland 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tanner

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9/2/2010 11:33A ^M Medical DOUGLAS ALEXANDER HAMILTON 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 6705 JAMES FARMER WAY CAPITOL HEIGHTS Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months 1 ★M 2 ☐ F Days Hours Min. 9/20/1939 Director RICHMOND, VA 70 <u>577-50-5376</u> Usual Residence of Decedent la or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND PRINCE GEORGE'S CAPITOL HEIGHTS 10e, Street and Number 10g. Citizen of What Country? Funeral er than "natural", or items 23a the Medical Examiner must b death with 6705 JAMES FARMER WAY 20743 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 Yes Give 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Specify: Completed BLACK Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Should be filed within 72 hand Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Resident Manager Private injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvin Lorenzo Hamilton Florrie Annie Williams permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela T. Hamilton / Daughter 6705 James Farmer Way Capitol Heights, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 9/11/2010 Alexandria, VA 21. Sign Jure of Funeral Service L 22. Name and Address of Facility Pope Funeral Homes, P.A. any LOY OLOPS 5538 Marlboro Pike Forestville, Maryland 20747 an Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CONGESTIVE HEART disease or condition FAILURE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Due to for as a gunse, units of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Pregnant at time of death Day g Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate 1 🗌 Yes 2 🙀 No 2**X** No Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? ျှ 2 X No Other: 1 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at hours after death. Ineral Director; After 28d. Describe how injury occurred 1 🛛 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital 24 hours Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) License number

State Registrar 9200 Basil Court Suite 200 Largo, Maryland 20774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Ivan Zama M.D.

31. Date filed (Month. Day

SEP 2 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 31293 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ _ Month Year 550 M 2010 PAULINE HEARN Nember Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death MICOMICO If Under 8. Date of Birth
(Month, Day, Year)
JAN. 2, 1921 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Min. Months Days Hours 89 **Director** 215-14-3197 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MARYLAND WICOMICO PITTSVILLE 10e. Street and Number 10f. Zip Code ٥ 10g. Citizen of What Country? "natural", or items 23a o with Funeral 6140 MORRIS ROAD USA 21850 filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: WHITE Specify: Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other thar event, the M Elementary/Seconday (0-12) College (1-4 or 5+) 8 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed trent of Health and Mental H rtant: If item 27 is marked ot ijury or other traumatic ever ပ္ RUFUS LITTLETON MAUDE BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6130 MORRIS ROAD, PITTSVILLE, MARYLAND 21850 DAVID HEARN/GREAT GRANDSON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If ii any injury or o Burial 2 Cremation 3 Removal from State 9/21/10 OWELLVILLE CEMETERY POWELLVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re Funeral-Service Licer 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Part t. Enter the disease, or complications that crused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Methicillin-resistant staphylococcal aureus equartially list our ditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) Day Year this certificate has been signed by the rail director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗶 No Other: ဂ္ 1 🗌 Yes 1 \$ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending work? 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ▶ mosha Peters - Hairis mo D70961 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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Harris MD

2 2010

32. Begistrar's Signature

21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year LTER ALVIN 9 THEVE 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death KOCHELLE Year If Under 24 Hrs. HARFORD IARYLANC 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min. **™** M 2□ F Yrs 225-50-2791 70 05/24/1940 VIRGINIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MARYLAND HARFORD FALLSTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2407 ROCHELLE DRIVE 21047 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates:1963-71 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC STEEL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CALVIN HARVEY LYNZELL MOSLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIA HARVEY / WIFE 2407 ROCHELLE DRIVE, FALLSTON, MARYLAND 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET 09/28/10 OWINGS MILLS, MD 22. Name and Address of Facility LISA SCOTT FUNERAL HOME 552 LEWIS STREET, HAVRE 21. Signature of Funeral Service Licensee , P.A. DE GRACE, MD 21078 Semon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 1/2 years disease or condition resulting in death) IMARY YELO FIBROSIS Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Exercines must be notified at

Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a
event, the Medical

7 is marked traumatic e

Item 27 other t

permit. Pages Department of Important: If It any injury or o

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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the Maryland

/Medical

10a. State

Examiner Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Be Completed by

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

9 Unknown

25. Was case referr examiner?						Place of De	ath (Check only one)
1 ☐ Yes 2 X	No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient	3 □ 1	Other: 4	☐ Nursing I	Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 2 □ Accident		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred
3 ☐ Suicide	6 Could not be		ome, farm, stree	t, facto	ry, office		28f. Location (Street and Number or Rural Route Number

4 Homicide building, etc. (Specify)

4940 Eastern

32. Registrar's Signature

City or Town. State.

(Check only one)			al Examiner: On	n the basis of examination and/or invest d manner stated.			ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
Oh Signaturo and	d title of o	-die	in. /		OOs Lisansa num	hav	00-1 D-1

30. Name and add/ess of person who completed cause of death (Item 23a) (Type, Print)

WECLF

Year)

EAH.

31. Date filed Month, Day,

5+IVA

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 20To MICHELE MARIE HINKLE 11,38A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 4, **Director** 45 Connecticut 217-94-2149 $\tilde{1}965$ Usual Residence of Decedent or items 23a or 28a-f shov 10a. State 10b. County 72 hours after death with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director New Market Maryland Frederick 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 11808 Pond Crest Court 21774 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: white If Yes, Give Year or Dates "natural", Specify 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 2 Child Care Child Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cathryn A. Campana Robert J. Landry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21774 11808 Pond Crest Court, New Market, Maryland Douglas Hinkle - husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9-20-2010 4 Denation 5 X Other (Specientombment Mt. Olivet Cemetery Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home ure of Funeral Service Scenses 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner meto St. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. **Other s**ign<mark>ificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy performe death? Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No မ 1 SInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? . After 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 \square Yes 2 🗌 No after death

Director: / Investigation 6 Could not be n 24 hours after de le Funeral Directo bleted filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the I within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Q,

DHMH 17 Rev 7/2009

State Registrar

10

1702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HARRIS-JOYNER eptember 14, 2010 1:26 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F Days Hours Months Director 578-60-7063 64 Vrs 5 1945 WASHINGTON, DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits PRINCE GEORGE'S LANDOVER HILLS 1X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 3615 GRUMBY STREET 20784 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: BLACK 3 X Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) GOVERNMENT SECRETARY and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 THELMA TUCKER NAPOLEON HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauonce. 3615 GRUMBY STREET LANDOVER HILLS, MARYLAND 20784 WYNORA A. HARRIS/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) 9/24/2010 SUITLAND, MARYLAND LINCOLN CEMETERY 21. Signature of Funeral S wire Licensee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CArdion disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cordiopulmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Of the Funeral Director: After this certificate has been signed by the attending physician and completed lilled in by the funeral director, page 2 should be detached for use as the burlar-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Encepholopathy Anoxic Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 XNo Month 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Diabeta Mellita 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 잍 fXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge death occurred at the time out, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number K. Michael September 14th 52865

State Registrar Glenn Dale.

MO.

20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12150 Annapolis Road, Ste 200

32. Registrar's Signature

31. Date filed (Month, Day, Year)

SEP 2 2 2010

2010

1800

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

29d. Date signed (Month, Day, Year)

Sept.20,2010

1 Yes 2 No

Mexico

White

To the Hospital or Attending Physician: npleted within 24

Registrar

DHMH 17 Rev 7/2009

1

State

29b. Signature and title of cer

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ira Weinstein M.D.

2. Registrar's Signature

D38445

600 Ridgely Avenue Annapolis, Maryland

10-07080 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 31298 State of Maryland / Department of Health and Mental Hygiene Bruce Stephen Hendricks 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Year 1240 hrs Medical Examiner September 14, 2010 Bruce Stephen Hendricks 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 11844 Beekman Place #709 Potomac Montgomery 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) NY Months Davs Hours Director 09/12/1950 60 2 F 095-38-8527 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 No 28a-f show ESITIMOFE, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature". Maryland | Montgomery Potomac Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11844 Beekman Place 20854 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 Yes 2 X No 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired)
Real Estate Developer Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate/Finance and Investor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Stanley Hendricks Muriel Helen Bernstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11844 Beekman Place, Potomac, Maryland Helene Hendricks, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Garden of Remembrance Memorial Park 09/16/2010 Clarksburg, Maryland 4 Donation 5 Other Specify ign ture of Funeral Service Licensee 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland MO1255 20852 P rt I. Enter the disease, or complication filure. List only one cause on each line. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical a. Intraoral Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Year 2 Day past 12 months? Pregnant at time of death 5 isigned by the atte 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, this certificate has been s director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 Yes To the Hospital or Attending Physician; within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be Other4 examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 V Other: Scene this ER/Outpatient 3 1 🗸 Yes ٩ 2 No 28a. Date of Injury To the Funeral Director: After the puppletely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Sep 14, 2010 Subject shot self 1240 hrs ___ Natural 1 Yes 2 V No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 11844 Beekman Place #709, Potomac, MD determined (Specify) Single Family Home 4 ___ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0(10)

DHMH 17 Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie

Russell Alexander MD.

Registrar's Signa re

and manner stated.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

September 15, 2010

29d. Date signed (Month, Day, Year)

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please Type or Print in Black In State of Maryland / Der	ndelible Ink. Ensure Al partment of Health and M	-	
	_1	1 - State Registrar Co	ertificate of Death	Reg.	No. 2010 31299
Physicia	n	1. Decedent's Name (First, Middle, Last) Mary K. Horner		2. Date of Death Month Septemb	Day 14, 201 Ye ar 05:50 PMM
/Medica Examine		4a. Facility Name (If not institution, give street and number) Frostburg Village Nursing Home	4b. City, Town, or Location of Death Frostburg		4c. County of Death Allegany
Funeral Director		5. Social Security Number 216-22-7459 6. Sex 1 M 2 F 7. Age (In yrs. last birthda, Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country) 13, 1926 Maryland
yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1			10d. Inside City Limits
the Mar 28a-f sl	rector	Maryland Allegany Frostbur 10e. Street and Number 20309 Klondike Road	10f. Zip Code	10g	1 ☐ Yes 2 No Citizen of What Country?
ath with s 23a or	Funeral Director		21532-		U.S.A.
al", o	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
in 72 ho n "natul	Completed	(Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	ing 16	b. Kind of Business/Industry
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wild be f Mental I arked of atic eve	To Be	William R. Ford	Mary Da	wson	
and 2 sho ealth and n 27 is m			iling Address (Street and Number or Rur 1) 1 Chisholm Line Road Fr	al Route Number, C Ostburg	ity or Town, State, Zip Code) Maryland 21532-
Pages 1 a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ematory or other place)	Date 200 aber 17, 2010	c. Location - City or Town, State Frostburg Maryland
permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Durst Funeral Home, 5	7 Frost Ave., 1	Frostburg, MD 21532
		23a. Part . Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.			i interval between
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The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medical		B ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
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The law require cate has been sig page 2 should b	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? ↑ 1 □ Yes 2 ♠ No
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ding Phy n. After thi funeral o	ion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
Hospita 24 hours Funera letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	rred at the time, date	and place, and due to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier Wormselfshi MD	29c. License number	290	Date signed (Month, Day, Year)
5		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	}	M 12/20
12 of Star	e	W ONSOCK SHIN 925 Bishop 1 31. Date filed (Month, Day Year) 32. Registrar's Signature	Nation Kel Cumb	er and	11/430
Registra	ar	SEP 16 2010 Samuel September 16 2010 September 1			

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			For State		State o	f Marylar		artment of I		nd Ment	al Hygie	2010	31300
			Registrar 1. Decedent's Name	(First Middle	l act)		Ce	rtificate of L	Death		Reg.	. No.	31000
	Physicia Medi		Doris	Elair	*	Hi11					ite of Death pt. 16	5 ^{Day} 2010 Year	3. Time of Death 10:30P M
المراجعة الم	Examir	ner	4a. Facility Name (if a			ber)		4b. City, Town, or LaPlata	r Location of I	Death		4c. County of Dea Charles	ath
	Funeral Director		5. Social Security Nu 578 54 855		S. Sex	7. Age (In yrs. I	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		te of Birth onth, Day, Yes	g. Bi Co Wash	rthplace (State or Foreign ountry)
	nd now	_	Usual Residence of I			10c Cit	y, Town or Lo	ecation			0, 270	7,100	
	farylar 8a-f sl tified	ecto	Maryland	Charles			Waldorf						10d. Inside City Limits 1 ☐ Yes 2XX No
	a or 28	٥	10e. Street and Num					10f. Zip Code			10g	. Citizen of What C	
	th with ms 23; must	Funeral Director	10761 Ce	darwood I				2060				United Stat	es
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marrie 3)(X) Widowed 4		Armed For	2 XX Vo		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2XXNo	n, Mexican, P	n? (Specify Yes Puerto Rican, o	s or No- etc.)	14. Race - Ame Black, Whit	te, etc.
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Baltimore, Maryland 21215-0036	ld be filed whental Hygarked otheratic event,	To Be	17. Father's Name (F	irst, Middle, Las NOWN)	st)				18. Mother's	s Name (First, evieve M	Middle, Maid		
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ē,	f Healt f Healt item 2		20a. Method of Dispo	osition		20b. P		Cedarwood Desition (Name of	Drive, W	<u>valdorf,</u> Date		01 c. Location - City or	Town State
E O	Page nent o		1 A Burial 2 □ 4 □ Donation	☐ Cremation 3 5 ☐ Other (Spe	Removal from	State c	emetery, crei	natory or other place eterans Cem				•	·
Balt	permit. Departr Importa any inju		21. Signature of June			48016	22	2. Name and Address	s of Facility I	ee Fune	ral Home	e,Inc 6633	Old Alexandria
Н			23a. Part 1. Enter th	e disease, or co	omplications that cay one cause on each	aused the death							Approximate
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3876	irtificat ling ph e as th	/Mec	IF FEMALE:		00-16								
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. The Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	onths?		Birth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregnance Other (specify)	y		_	23d. Date of de Month	livery Day Year
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ord	v requi	olete								24	a. Was an	/ -	topsy findings available
Rec	The lav ate hax page 2	Completed								_ _	autopsy performed Yes 2	prior to death?	completion of cause of
ā	ician: certific ector,	Be	25. Was case referred examiner?		Hospital:					Check only or		110	2010
<u>></u>	Phys	e: 1	1 Yes 2 2 27. Manner of Death	,No	1 🗆 Ir	npatient 2	ER/Outpatier 28b. Time of	t 3 DOA Othe	4 L Nursir		Residence	6 Other (Spec	ify)
ouo	ending eath. or: Afte he fune	licat	1 Natural 2 Accident	5 Pending Investigat	(Month	n, Day, Year)	injury	work?	າ ^ລ ີ Yes 2 □ No		scribe now in	jury occurred	
DIVISI	ital or Att ins after de al Directo led in by t	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	28e. Place c	of Injury - At hor g, etc. (Specify)	me, farm, stre	et, factory, office			cation (Street a or Town, Sta	an d Number or Rui ate)	ral Route Number,
	o the Hospital of thin 24 hours at the Funeral D ompleted filled in	Medical	only one) 3	☐ Medical Exa ☐ Certifying N	miner: On the basis	of examination	and/or invest	ccured at the time, igation, in my opinior leath occurred at the	 death occur 	red at the time	date and pla	ice and due to the	causea(e) and mannor stated
	vit Cor	- 1	29b. Signature and tit	_				29c. License				Date signed (Month	
		}	Hawx 30. Name and addres	s of person who	Completed cause	of death (Item	23a) (Type D	D465	16		0	9/20/2	0/0
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	Stat Registra	e Ir	HAWANT TO 31. Date filed (Month,	EP 22 2	2010 32 Aleg	gistrar's Signatu	9. be	ake					
					18.7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ SEPTEMBER ¹16, 2010 VIRGINIA HOLLENCZER 1:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 804 MASON ROAD STEVENSVILLE QUEEN ANNE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 1 □ M 2 🛣 F 78 Months MAYONT 1 0 34, 1932 Director 407-38-7784 KENTUCKY Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits r 28a-f sl notified MARYLAND QUEEN ANNE'S STEVENSVILLE 1 🗌 Yes 2 🛣 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral with 1 23a 804 MASON ROAD 21666 UNITED STATES 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. ō 1 Never Married 2 M Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify "natural", WHITE Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LLOYD BACK SALLY ADAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau JOSEPH J. HOLLENCZER/HUSBAND 804 MASON ROAD, STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION CENTER 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 22 Name and Address of Facility FELLOWS, FUNERAL HOME, P.A., 106 TAK I s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, seen each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AbdomINA nco/1/xsm Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Devere dementix 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Aortic anengsm 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA s after death.
I Director: After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 Accident
3 Suicide 2 🖵 No Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

State

only one

30. Name and

29b. Signature and title of certifier

31. Date filed (Month, Day Year)

Registrar DHMH 17 Rev 7/2009 ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MA

HARMS

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

STEVE NSULCE

09-17-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Hovey 7:44 PM Terry September 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 7611 Locris Drive Upper Marlboro 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XXF Oct 19, 1930 Japan 356 32 6050 79 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Prince George's Maryland Upper Marlboro 1 Yes 2XX No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7611 Locris Drive 20772 United States or items ould be filed within 72 hours after death to Mental Hygiene. marked other than "natural", or items matic event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2X Married 1 Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Completed Japanese Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homeowner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of and 2 should be file of Health and Mental H fitem 27 is marked of rother traumatic ever ည Miyoshi Sadohara Asako Ewao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald A. Hovey (Spouse) 7611 Locris Drive, Upper Marlboro, Maryland 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o XXX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) 9/21/2010 Maryland Veterans Cemetery Cheltenham, Maryland 21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death END-Stade LIVER DISCASE Ph_sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Eller challenging Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death the 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred / medical æ 26. Place of Death (Check only one) examiner? 2 🗷 No Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 🖟 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contriging Number Fraction on T. The cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 _ Gurfflying Nurse Practioner: To the best of my knowledge, dr 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ns Rajapahre M.D D0057 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. RAJA PALSE, M.D. 28355 min Av-S-203, Baltimore, MD.

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State

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09/19/2010 Physician/ Louis Paul Helmick 11:38 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 🔀 M 2 🗆 F 0971671921 314-16-6640 Director 89 IN Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. ıral", or items 23a or 28a-f sho Examiner must be notified at Director MD Anne Arundel Friendship 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6514 Wilson Road 20758 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married X Yes Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural" Completed 3 🗆 Widowed 4 🗆 Divorced Year or Dates the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mail Sorter Postal Service other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Paul R. Helmick Veronica Hornett and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health a Zwanda Helmick / wife 6514 Wilson Road, Friendship, MD 20758 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Department Important: I any injury o Arlington Nat'l Cemetery 101/05/2011 Ft. Myer, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home CAlvert, P.A. of Funeral Service Licens Signature Barv Goff 8125 Southern Maryland Blvd., Owings, MD 20736 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ TODG FINS Medical resulting in death) Due to (or as a consequence of) Examiner SPIRATE Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit FAILURG TURIV that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 2 No detached g 🗌 Unknown n signed by t Id be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate hompleted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Universing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20-2010 W 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harshinder Sighu 100 HOSPITAL ROAD WINCE FYLOUNCE I'M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 1 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Ú Physician/ 2010 NDRICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Hospital <u>Annapolis</u> <u> Anne Arundel</u> Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 08/04/1948 Country)
West Virginia 62 Director 236-72-3262 Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Prince Georges Bowie 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 12725 Kembridge Drive 20716 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Yes 2 🛚 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Construction <u>Master Electrician</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Auttie T. Hendricks Viola Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Upper Marlboro, MD 20774 <u> Christina Powell</u> - Daughter 17823 Central Avenue injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 9/23/2010 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. any Brentwood, MD 20722 3401 Bladensburg Road 23a. Part 1. Inter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Beath shock, or heart failure. List only one cause on es Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consecuence on: death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) 4 ☐ Pregnant a
9 ☐ Unknown 9 Unknown us been signed by the should be detached Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Linknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 N/6 2 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: After 1-Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu death. ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2010 Name and address of person who completed cause of th (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Date filed (Month, Day,

2

2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 0 | 3 | 3 0 5 Janet Lee Harris-Hillard Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Medical Examine Month Day Y September 24, 2010 Janet Lee Harris-Hillard 0641 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11502 Metronome Court Prince George's Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Foreign 1,47-42-6450 45 05/02/1965 1 M 2 F Country) Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Clinton 1 X Yes 2 No with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11502 Metronome Ct. 20735 AZU Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Pages 1 and 2 should be filed within 72 hours after death minent of Health and Mental Hygiene.
 If item 27 is marked other than "natural", or item or other traumatic event, the Medical Examiner must b or other traumatic event, the Medical Examiner must b Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Marrie White, etc. 1 X Yes 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 No specify: Specify: Black ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 75 Е Law Firm Paralegal 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Henry Harris Clara Elizabeth Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11502 Metronome Ct., Clinton, MD 20735 James C. Hillard / husband 20a. Method of Disposition ftimore, 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 09/30/2010 Cheltenham, MD 4 Donation 5 Other Specify of ature of Funeral 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 rt I. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard se on each line. Cardiac Arrhythmia due to Myocardial Fibrosis Physician Approximate Interval Between Onset and /Medical Pending Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical 23a,27 per me g913 3-28-11 vt signed by the attending physician be detached for use as the burial X UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy past 12 months? Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown has been page 2 should 24a. Was ar 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician; Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 🗹 Other Scene 1 Yes this Inpatient 2 ER/Outpatient 3 DOA ဥ No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural Director: / 5 Pending 24 hours after death. 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 25, 2010 Minaneo 30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 32. Registrar's Signatu

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Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ISENBERG-GADOW Physician/ SEPTEMBER 11, 2010 ESTER 01:33 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMOR & If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕅 F (Month, Day, Year) av 15. 1957 Maryland 217-68-7585 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No MD Calvert Lusby 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11660 Cowpoke Circle 20657 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) administrative assistant PG Fire Logistics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည E1wood Myron Isenberg Mae Mary Skinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11660 Cowpoke Circle, Lusby, MD Thomas S. Gadow, husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 09/16/2010|Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. of Funeral Service Lice 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SOFT TISSUE INFECTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CALCIPHYLAXIS Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ned by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MOLLITUS DIABETES Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown GNO STAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division ☐ Accident Investigation by the f 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed within 2 only one 29b. Signature and title of certifier RES - 000 S. GROENE ST. BALTIMORE, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW MARKANDAYA MANJUNATH

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

of Vital

backer

32. Registrar Signature

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	with the	Funeral Director	10e. Street and Number 703 Taft Court			10f. Zip Code 21804	1		10g. Citizen of W USA	/hat Country	y?
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9036	ırs after ural", o I Exam	ed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		1 ☐ Yes 2 🖾 No	Specify:		Specify:	Black	k
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and	be filed ental H rked ot ic ever	To B	17. Father's Name (First, Middle, Last) Pete Wall				18. Mother's Nam Mabel	e (First, Middle, Holbroo		1	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (T)	• •		ng Address (Street a					
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	h sician/ Medical	7 3	Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conse	Aug	te Renal "	Failure			-	mset and Death
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ž į	n: The la ficate ha n, page		25. Was case referred to medical				45 11 (2)	1 🗌 Yes	med? d	eath?	
Vita	nysiciar nis certi directo	To Be	examiner?	Hospital:	☐ ER/Outpatien	Lotha	ace of Death (Checker: $4 \square$ Nursing Ho		ence 6 🗆 Other	r (Specify)	19 <u>92</u>
n or	aing P		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe h	ow injury occurre	d	
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	thin 24 the Full the	Medical	only one) 3 Certifying Nurs	ner: On the basis of examinative Practioner: To the best of	ion and/or invest my knowledge, c	eath occurred at the	time, date and plac	e, and due to the	cause(s) and mar	nner as state	ed.
	5 5 %		29b. Signature and title of certifier	h		29c. License	7 0 9 4		29d. Date signed		y, Year)
	Ker		30. Name and address of person who o	ompleted cause of death (Ite	em 23a) (Type, P	rint)	SALISB	المناه	4/22 MD 218	roly	
180	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	steet land		,			
	Registra	r	SEP 2 2 2	2010 Denna	A. A	ack					

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 201[°]Car 22 Betty Lou Johnson AM 2:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7335 Brookview Road Apt. Howard Elkridae Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 XF Months Days Hours **Director** 77 1071771932 212-30-4278 Yrs. MD Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🛂 No MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7335 Brookview Road Apt. be filed within 72 hours after death wi ental Hygiene. 'ked other than "natural", or items 2 ic event, the Medical Examiner musi 21075 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No If Yes, Give 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Howard Co. School Sys. Be it. Page 1 and 2 should be filed rtment of Health and Mental H-rtant: If item 27 is marked of njury or other traumatic ever 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert C. Struder Olga Bigalke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E.Donald Johnson - Husband 7335 Brookview Road Apt. 206 Elkridge, MD 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) John's Luth. Cem. 09/25/2010 Waterloo, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Ind. 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Hemorr Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown peen Hem, paresis 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 Yes ည 2 X No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 eral Director: After this certificate has filled in by the funeral director, page 2.3 within 24 hours a

To the Funeral C

completed filled

> 50,18 Dorsey Hall () Registrar's Signatu State

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year) 05 10

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2104 rive suite 104

Registrar

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 14 2010 1:55 PM JANNIE Н. **JOHNSON** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Mandarin House Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours Min. Day, Y Director 251-58-2098 78 1**ँ**932 Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 X No MD PRINCE GEORGES LANHAM 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6204 SEABROOK RD. 20706 USA "natural", or items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Specify: BLACK the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH SEAMSTRESS SELF-EMPLOYED permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If flem 27 is marked any injury or other transported. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, JOSEPH WHEAT HAM ANNIE COOPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANEL BURCH - GRANDDAUGHTER 6204 SEABROOK RD. LANHAM, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory of MEADOW PRONG BAPT. CHURCH or other place) 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 9-20-2010 EFFINGHAM, SC 21. Signature of uneral Service Licensee MARSHATE MARKEH HOME OF MARYLAND SUITLAND RD SUITLAND, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death YRS shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) METASTATIC COLON CARCINOMA Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Year Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 2X No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes NON-INSULIN DEPENDENT DIABETES MELLITUS Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 X No death? 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 🗆 Yes 2 🔀 No Hospital မ Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE After this 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 \square Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after deat Funeral Director: within 2 To the

Baltimore, Maryland 21215-0036

KAREN BLEDSOE,

elsoemo

Md D0043180

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7404 EXECUTIVE PL. #501 LANHAM, MD 20706 MD 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signatuye and title of certifier

31. Date filed (Month, Day, Year)

SEP 2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ida Lee James September 2010 Medical 5:08 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign 1 □ M 2**X5X**F Months Days Hours Rocky Mt. N.C. 87 Director 242-09-7831 05/03/1923 Usual Residence of Deceden or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at n "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director D.C. Washington 1x Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 526 48th Pl., N.E. 20019 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedon. Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🙀 Married <u>چ</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Black 3 - Widowed 4 - Divorced Completed Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Perry Hunter Della Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel James/Husband 526 48th Pl., N.E., Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harmony Mem. Park <u>09/25/10</u> Landover Maryland Signature of Funeral Service Licens 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications of the disease of complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Applications of Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrhythmia
Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Hypertensive Cardiovascular Diseas Sequentially list conditions if any list districtions cause. Enter Underlying Physician/Medical Examiner to for as a our sucuriou of To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed ☐ Yes 2 X No 1 Tes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 🗡 ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral dir 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direc 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tity of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 32. Registrar State SFP 2 2 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 12 2010 Kyle Raymond Jackson, II 7:17 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 1**X** M 2 □ F Min. Hours 3 0971472010 Mary Land Yrs None Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1xx Yes 2 ☐ No Md Prince Georges Fort Washington 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4213 Steeds Grant Way 20744 Usa 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Kyle Raymond Jackson, Sr. Ashley Kristen Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Ashley Kristen Peterson/Mother 4213 Steeds Grant Way Ft. Washington, Md 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory09/23/2010 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Rome 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death hours disease or condition resulting in death) Extreme Prematurity Due to (or as a consequence of): Respiratory Failure 3 hours Sequentially list conditions, if any. leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) 3 hours <u>Hypovolemic Shock</u> that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Day Pregnant at time of death Month Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2√ No 3 Probably 4 Unknown

Physician/ Medical **Examiner**

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certificate ha irector, page 2

After this

To the Funeral Director: completed filled in by the

Medical

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic average.

Funeral

Director

Physician/Medical Completed by Be မ Certificate:

25 Was

27. Man

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the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy

				1 Yes 2 No 1 Yes 2 No
case referred to medical iner?			26. Place of Death (Chec	ck only one)
Yes 2 🔀 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆	OCA Other: 4 \(\sum \) Nursing H	tome 5 ☐ Residence 6 ☐ Other (Specify)
ner of Death Natural 5 Pending Accident Investigation Suicide 6 Could not b		28b. Time of injury		28d. Describe how injury occurred
Homicide determined	e 28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factor	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

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29a. Certifier	1 Certifying Physician	r: To the best of my knowledge, death occur-	ed at the time, date and place, and due to the	cause(s) and manner as stated.
(Check	2 Medical Examiner: 0	On the basis of examination and/or investigation	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated
only one)	3 ☐ Certifying Nurse Pra	actioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b. Signature a	and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09/14/2010

Dawn M. Walton, MD 1500 Forest Glen Road Silver Spring, Md 20910

State Registrar

31. Date filed (Month, 32. Register's Sign

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	State Registrar					Ce	rtificate of	Death_			Reg. N	201	0	3 3 2
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Medic		Nellie	P. Jack	son									Ž010_		5:38 A ^M
Examin	er	4a. Facility Name (if	not institution,	give street an	d number)			4b. City, Town, o	or Location of	of Death		4	c. County o	f Death	
		8661 Lang 5. Social Security N	gmaid Re	oad S. Sex		no (In ura la	ant hirthday)	Newar		24 Hre T	8. Date of Birt			cest	
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or ite	y Ft	11. Marital Status1 Never Marr	ied 2 X Marrie	Arm	ed Forces? Yes 2	No.	5.	If Yes, specify Cub	an, Mexican	, Puerto F	Rican, etc.)		14. Race Black	- Americ , White,	
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12 sh alth an 27 is rtrau		Robert W				and		Langmaid						10, 21p C	5040)
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Page nent a ant: II			☐ Cremation 3 5 ☐ Other (Sp		from State	Bow	zen Cei	natory or other pla netery	S	ер.	22, 10	New	ark,	MD	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lic	ensee			22	2. Name and Addre	ess of Facility	y Bu:	rbage F	une	ral H	ome	
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he la ite ha	mo;										autop perfor	rmed? 2 🗷 N	de	ath?	mpletion of cause of 2 No
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hysic his ce Il direc	힏	1 🗆 Yes 2 🖸		Hospital:	1 🗌 Inpati	ient 2 🗆		nt 3 🗆 DOA Oth	er: 4 🗌 Nu	rsing Hon	ne 5 Resid	lence	6 🗌 Other	(Specify)
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 burus after death. with 24 brouns after death. completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1	Certifying F	hysician: To	the best of	my knowle	edge, death	occured at the time	e, date and p	olace, and	due to the cau	use(s) a	nd manner	as state	d.
he Ho in 24 he Fu iplete	Med	(Check 2	Medical Ex	aminer: On th	ne basis of e	xamination	and/or inves	tigation, in my opinideath occurred at th	on, death oc	curred at t	he time, date a	nd place	e, and due to	o the cau	use(s) and manner stated
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 15, 2010 Year Georgia Lee Jones 5:55 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Owings** 1914 E. Chesapeake Beach Road Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. **Funeral** 8 Date of Rirth 9. Birthplace (State or Foreign Hours Min (Month, Day, Year) July 3, 1932 Country) Director 215-36-5030 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No MD Calvert **Owings** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1914 E. Chesapeake Beach Road 20736 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: Black the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) **Factory Worker Furniture** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot jury or other traumatic even **Bertis Jones** Helen Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debora Harris - daughter 1685 Joe Harris Road, Prince Frederick, MD 20678 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o Cheltenham Veterans Cem. | September 22, 2010 | Cheltenham, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Blady 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Acute Myorardial Infarction Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner tentoscherotte Cardiovascular Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Disease - diffuse been signed by the attending physician and should be detached for use as the burial-transit Coronary Artery The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 I No Other: 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? X Natural injury 5 Pending Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 20,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gerald P. Sterner M.D. P.O. Box Gerald 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stanley William King September 17,2010 ear 2:55 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 211 Gingrich Drive Accokeek 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Sept 24. 577 52 9404 86 Director Vrs Newport Wales Usual Residence of Decedent 28a-f shov 10b. County 10a. State death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Accokeek 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 211 Gringrich Drive 20607 United States items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 5 Completed by 1 Never Married 2 Married 1-Yes 2 No If was, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify: "natural", 3 ₩ Widowed 4 □ Divorced Specify White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the US AIr Force 12 other Supply Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I .. Page 1 and 2 should be filk tment of Health and Mental tant: If item 27 is marked o ည Albert King Kathleen Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Havenner (daughter) 211 Gringrich Drive, Accokeek, MD 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Lee Crematory Septe 23, 2010 22. Name and Address of Facility e of Funeral Service Licensee moiss Lee Fuenral Home, Inc 6633 Old Alexandria rerry Road, Clinton 23a. Par 1. Enter the disease, or complications that causeu shock, or heart failure. List only one cause on each line 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ONONA Medical resulting in death) Due to (or as a consequence f) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery that the death ō in the past 12 months?

1 Yes 2 No Month Day the Unknown 9 Unknown P.O. ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify eral Director, After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ☐ Natural work? 1 🔲 Yes 5 Pending THERE Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, building, etc. (Specify) street, factory, office determined after within 24 hours a

To the Funeral D

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 17 2010 LAWSON 6:52 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 805 CHILLUM ROAD HYATTSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🖺 F Days Hours Min SEPT 20 1926 FLORDIA Director 266-34-8958 83 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGE'S CHILLUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 805 CHILLUM ROAD 20783 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 24 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ori 1 Never Married 2 XMarried þ Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: other than "natural", Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH ACCOUNT TECHNICIAN GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev JOHN SOWELL FLORENCE ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR V. LAWSON/SON 32nd STREET N.W. WASHINGTON, DC 20015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State PARKLÁWN CEMETERY 9/25/2010 4 Donation 5 Other (Specify) ROCKVILLE, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CORONARY ARTERY DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner <u>ATHEROSCLEROSIS</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or linjury that initiated events and -tran: Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending physi I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page performed? Yes 2 4 death? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 X No ဂ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No s after decral Director: After injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) re and title of certifier 29b. Signate 29c. License number 29d. Date signed (Month. Day, Year) SEPTEMBER 21, 2010 D41507 POV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) SEP 2 2 2010 32. Registra 's Signature

NANCY DAVENPORT M.D. 3301 NEW MEXICO AVENUE WASHINGTON, DC 20016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Herbert Louis Landolt, III 2010 September 2:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6351 Spring Ridge Parkway Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🕅 M 2 🗆 F Hours Washington, DC **Director** 578-74-8775 56 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Frederick 1 🛣 Yes 2 □ No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6351 Spring Ridge Parkway 21710 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 X Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert L. Landolt, Jr. Mary Rolfes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Landolt / Brother 10223 Sunway Terrace, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If it
any injury or of 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 9/25/2010 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue jones. Gasch's Funeral Home, PA EAN Rogers Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Cardinmyopath disease or condition Medical resulting in death) Due to (or as a consequer of o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death detached 2 No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by moloumon 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has autopsy perform death? Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D63183 20 comer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK KANNAN SHRI MD 200 CRESTWOOD 7190 BLVD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 2 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 14, September 2010 4:00 pM Robert Leonard Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Montgomery Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 1 X M 2 □ F Days Director 90 1919 578-16-6529 Dec 12, Washington, Usual Residence of Decedent Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f shore Examiner must be notified at Funeral Director 1 X Yes 2 □ No MD Rockville Montgomery the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 20852 6121 Montrose Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1944 − If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify þ Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: White "natural" Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Interior Decorator Furnature 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Pach Harry Lewis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Chichester Lane, Silver Spring, Maryland 20904 Donald Garner/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Crematory 9/16/2010 Falls Church, Virginia 4 Donation 5 Dother (Specify) 22. Name and Address Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licensee ill Cornelmont MO1597 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End **Physician** Stage disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. End to we ying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s autopsy perform certificate 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient မှ 2 ER/Outpatient 3 DOA 4√ Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: s after de... filled in by 24 hours a

Baltimore, Maryland 21215-0036

within 24 hor To the Fune

2 3

> State Registra

Medical

Fazli 6105

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Motrase

Rockville 20852 MD

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and title of certifier

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 0 3 | 3 | 8 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	cate of	Death			F	Reg. No.			
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director page 2 should be detached for use as the burial – transition of the funeral director, page 2 should be detached for use as the burial – transition of the funeral director of the funeral	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	e 1 Liv 4 Pre	es, outcome of e birth egnant at time	a af da atla	2 Feta	il death 3 er (S <i>pecify</i>)	B Ec	topic pregna	ancy		Date of o	delivery Da	ay Year
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H 3 H 2	Ĭ	29b. Signature and title of certifie					29c. Licer	nse num	ber			ate signe ember		h, Day, Year)
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Stat	te	Donna M. Vincenti, M. 31. Date filed (Month, Day, Year)	3/	Registrar's	Examiner Signature	park	Penn Stree	ı, Balı	iimore, M	1201 ∠ U				_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 40 PM ewis 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany lonaconing Si Home Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 1 1 F 97 215-42-4951 Director March 15, Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, the fredient Examination and 1 ☐ Yes 2 No Allegany Director Maryland Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 175 Mount Pleasant Street 21532-USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev James Albert Broadwater Martha Catherine Platter ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Stafford daughter 21539-2592 Pea Ridge Road Lonaconing Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park Frostburg Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1. Lole Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 454 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerchovesouler acciden 4days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

the death certificate be executed and signed by the attending physician a P.O. Box 68760, Division of Vital Records, peen has certificate To the Hospital or Attending Physician: within 24 hours after death.

C To the Funeral Director: After this certifica completely filled in by the funeral director, p

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is marked other than

es 1 and 2 should be fill of Health and Mental H item 27 is marked oth

within 72 hours after death

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated 29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deulin M.D. Ave., Longconing, md 21539 20

State Registrar

31. Date filed (Month, Day, Year) 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carol SEPTEMBER 15, 2010 Judith Layman 15:11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS - REGIONAL MEDICAL CENTER ALLEGANY CUMBERLAND 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days Mary Tand 216-38-1835 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 ☐ Yes 2 🗓 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12416 Old Mount Pleasant Road, NE 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced White Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Cook Concessions Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o 2 Yaider Henry Roman Alice Virginia Blubaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald A. Layman / Husband 12416 Old Mt. Pleasant Road, NE, Cumberland, 1 and 2 s of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If its
any injury or or X Burial 2 Cremation 3 Removal from State Hillcrest Mem. Park 09/20/2010 Donation 5 Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Rome. gnature of Funeral Service 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ OIYC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 attending p for use as 1 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year ed by the detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🔀 No မ 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural
2 Accident 5 Pending 1 Tyes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined **بالان** م 24 hour. د **the Funeral D**. د د مسpleted fille Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 D66150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nas NAEEN, MUHHAMMAD M.D. 625 KENT AVENUE, SUITE 204, CUMBERLAND, MD 21502 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of	Marylan	•	artmen <i>tificate</i>			and M	-		010	3133	1
		Registrar 1. Decedent's Name (First, Middle, L	ast)		Cer	uncate	OIL	eam		2. Date of De	Reg. No.	010	JIJZ	1
Physici Medi		Theodore Light								9/9/10		Year	3. Time of Death 6:31 P	M
Exami		4a. Facility Name (if not institution, g						Location of	of Death			ounty of Dea		
		Atlantic Gene 5. Social Security Number 6		oıta⊥ . Age (In yrs. Ia	and the leader when all		erli	If Under	24 Uro T	0.D. (D)		rces		
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d t ow	٦.	Usual Residence of Decedent 10a. State 10b. County		10c Cit	, Town or Loc	otion	_						10d. Inside City Limit	
arylan a-f sh fied a	Funeral Director					ation							1 🗆 Yes 2 🖼	
or 28	Ë	MD Worcest 10e. Street and Number	<u>er</u>	Ber	lln	10f. Zip	Code				10a, Citize	n of What Co		
with t	eral	38 Grand Port R	d			218	11				US			
leath items	표	11. Marital Status	12. Was Deced	ent Ever in U.S		vas Deced	ent of His			cify Yes or No- Rican, etc.)		. Race - Ame	erican Indian,	
Baltimore, IMaryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 № Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 🖾 Yes 2 If Yes, Give	⊇ □ No		Yes	_			nicari, etc.)	Spi	Black, Whit		
nours natura ical E	ete	15. Decedent's		es.	16a. Deced	ent's Usua	Occupa	ition			16b Kind	of Business	Industry	-
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ould b		19a. Informant's Name/Relationship	(Type, Print)		19h Mailin	a Address	(Street a			Route Numbe	r City or Tol	un State 7	n Codel	
Mar d 2 shou alth and 27 is m			son			-							, VA 2323	5
of Her of Her fitem		20a. Method of Disposition			ace of Dispos	ition (Nam	e of			ate			Town, State	
Page ment tant: I		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)		e Her	lope	en C	re					rd, DE	
Salumore, bermit. Page 1 and Department of Hea mportant: If item any injury or other		21. Signatur of Hyreral Pervige Lice	nsee							Burbag			Iome	
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or use	ian/	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal	death 3			,			230	d. Date of de Month	livery Day Year	1
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quires quires en sig ould by	ted									1 🗆	Yes 2	No 3 🗆 P	robably 4 - Unknow	vn
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sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Louis	ce of Deat						\dashv
a Physer this eral di	e: To	27. Manner of Death	28a. Date of		28b. Time of		c. Injury	at		ne 5 🗌 Resid 8d. Describe h			sify)	\dashv
ath. or: Afte	ficat	1 Natural 5 Pending 2 Accident Investigat	ion	Day, Year)	injury	М	work?	res 2 🗆	No					
VISION or Attendir fler death. Sirector; Aff	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of	Injury - At hor , etc. <i>(Specify)</i>	ne, farm, stre	et, factory,	office		2	8f. Location (S City or Tow		umber or Ru	ral Route Number,	
spital ours a neral D		29a. Certifier 1 Certifying Pl	nysician: To the bes	t of my knowle	edge, death o	cured at t	he time	date and r	place and	due to the ca	ise(s) and m	anner as st	ated	-
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Vithi To th	-	29b. Signature and title of certifier	0 0				License ı				_	igned (Month	n, Day, Year)	
		I will !	Thhui	~ h	0		006	,646	2		9-1	0-10		
H1	ĒΤ	30. Name and address of person who	completed cause	of death (Item :	23a) (Type, Pr	int)	n n		2.~-1).	n 10-10	71011			
Sta		Jeffrey R SJ 31. Date filed (Month, Day Year) SEP 21	32. Reg	LOT Istrar's Signatu	ire Ke	ettre	es/2 R	_es 1)	yen (1 VNU	١١١ع			\dashv
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Physici Medical Exam		Registrar 1. Decedent's Name (First, Middle Francis William					_		- 1	Date of Dea Month Septemb	ath Day	Year	3. Time of Death 1445 hrs
		4a. Facility Name (if not institution 450 North Juniata Street	n, give street and n	umber)		4b. City, Tow Havre de						ounty of Deat	th
Funeral Director		5. Social Security Number 220–62–9470	6. Sex	7. Age (In yrs. 57	•		Year Days	If Under Hours	_	8. Date of B	inth(MM/DD/	Fore	rthplace (State or ignWashington, DC ountry)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Harfor 10e. Street and Number 450 North Junia 11. Marital Status 1 Never Married 2 X Ma 3 Widowed 4 Div 15. Decedent's Education (Specent Secondary (0-12) 17. Father's Name (First, Middle, Theodore Lom 19a. Informant's Name/Relations Dee Ann Lombar 20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Secondary 21. Signague 1 April 19 Secondary 22. Signague 1 April 19 Secondary 10b. County 10b. County 11b. County 11b. County 12b. Maryland 12b. Cremation 12b. Cremation 12b. Signague 1 April 19 Secondary 10b. County 10b. County 11b. Cou	arried 12. Was De Armed Find 13. Was De Armed Find 14. Was De Armed Find 15. Was De Armed Find	cedent Ever in Uorces? 2 X No ar de completed) 1-4 or 5+) 2 ars	19b. Mail 193 Place of Disportermatory or alas C	de Grac 10f. Zip Co 210 Was Decedent of Yes, specify Co Yes 2 X Jent's Usual Decommost of working and Address (S) Magoth Position (Name of other place) Temator Name and Address Address (S)	78 f Hispan, Nossupation, Iffe. D	Mexican, specify: n (Give kilo NOT u Mother's and Numb each tery,	ind of wor use retired s Name (F Mar; Deer or Run Rd.	ify Yes or No can, etc.) k done irst, Middle, garet al Route Nur , Pasa Date /10 ge P.	Reh Maiden Sun Beats mber, City on dena, 20c. Loca Edg Kalas	white, etc. ecify: V of Business abilit mame) son MD 21 etion - City of	rican Indian, Black, White Vindustry Cation Ctr. e, Zip Code) 1122 r Town, State
Physician /Medical zxaminer	Examiner	23d. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	on each line. a. Athero Due to (or as a b. Due to (or as a c. Due to (or as a c.)	a consequence of	of):								Between Onset and Death
ords, P.O. Box 68760, requires that the death certificate be executed sheen signed by the attending physician and should be detached for use as the burial - transit	ompleted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk Part II. Other significant conditi Chronic Alco	1 Live b 4 Pregr nown 9 Unknoons contributing to	outcome of preg pirth nant at time of de own	path 5	Fetal death Other (Specify)	3	Ectopic p	pregnancy	23e. Did to	23d. Da Mor	contribute to 3 Prol 24b. Were au prior to	Day Year the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bun	Medical Certification: To Be Comp	3 Suicide 6 Could detent 29a. Certifier 1 Certifying Phone) 2 Medical Exam 29b. Signature and title of certifier 30. Name and address of person	Hospital: 1 28a. Date (Month ing tigation d not be mined (Specify) sysician: To the best and manner systems of the basis o	e of Injury - At his st of my knowled of examination a lated.	ge, death occ ind/or investig	nt 3 DOA f Injury 28c. 1 reet, factory, officeurred at the time pation, in my opin 29c. Lic O.	Yes ce build date nion, de	ner at Work? 2 N And place and place ath occurrence.	28 28 and during at the	1 Yes y one) dome 5 d. Describe f. Location (sor Town, See to the cause time, date	Residence how injury of Street and Notate) Se(s) and mand place, and place,	Number or Ru anner as stat and due to th	r: Scene ural Route Number, City ed. e cause(s) nth, Day, Year)
St Regist	ate	Victor Weedn MD JD 31. Date filed (Month, Day, Year)	Assistant Me			Penn Street			MD 21	201			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	of Maryland / Depa	rtment of Health a tificate of Death		giene Reg. No. 2010	31323
Physician /Medical			1. Decedent's Name (First, Middle, Last) ZADIE McQUEEN			2. Date of De Month SEPT	ath Day 2010	3. Time of Death
Examiner			4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL		4b. City, Town, or Location of FORT WASHINGT		4c. County of Dea	
Funeral Director			5. Social Security Number 6. Sex 1 M 2 X F	7. Age (In yrs. last birthday)	If Under 1 Year		th 9. Bi	rthplace (State or Foreign ountry)
and	wc		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation	, , , , , , , , , , , , , , , , , , ,		10d. Inside City Limits
- Maryl	Health and Mer em 27 is marke ther traumatic	I Director	DC	Washingto				1 X Yes 2 □ No
with the			10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
er death		Funeral	72 55TH Street SE 11. Marital Status 12. Was Do Armed	ecedent Ever in U.S. 13. V Forces?	20019 Vas Decedent of Hispanic Original Yes, specify Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Am Black, Whit	
5-0036 72 hours afte		ò	If Yes,	s 2 🛛 No	□Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: B	•
1215-(rithin 72 h		Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) (Give	lent's Usual Occupation kind of work done during most DO NOT use retired) RIAL SEAMSTRE		16b. Kind of Business U.S. POSTA	ŕ
Ma 2		Be Co	12 17. Father's Name (First, Middle, Last)	INDOOL		's Name (First, Middle,		——————————————————————————————————————
Maryland d 2 should be file		To E	HENRY L. CHAPPELLE		LOREE			
			19a. Informant's Name/Relationship (Type. Print) TERRY CHAPPELLE -GREAT NEPHEW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 72 55th STREET SE WASHINGTON DC 20019					
			20a. Method of Disposition 1 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State					
Saltimore, permit. Pages 1 ar			4 Donation 5 Other (Specify) LINCOLN MEMORIAL Sept 20 2010 SUITLAND MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility POPE FUNERAL HOME					
5538 MARLBORO PIRE FORESTVILLE M								LAND 20747
	ysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between ginses and Death					
	Medical aminer		Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					
patr	physician and the burial-transit	ed by Physician/Medical Examiner						
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DOX	hin 24 hours after death. the Funeral Director: After this certificate has been signe npletely filled in by the funeral director, page 2 should be d		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Liv 1 □ Vac 2 □ Mais 4 □ Pre	Ectopic pregnancy		23d. Date of delivery Month Day Year		
at the d			9 Unknown 9 Un	Other (specify)				
v requires th			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did to		cco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
he law r		Completed				24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
cian: T		BeC	25. Was case referred to medical examiner?		26. Place o	1 ☐ Yes of Death (Check only of	2 XNo 1 ☐ Yes	2 □No
Physi		2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury. 28b. Time of 28c. Injury at 28d. Describe how injury occurred					
ending			1 ☑ Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	28c. Injury at Work? M 1 □ Yes 2 □ No		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
ital or Att		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		et, factory, office			28f. Location (S City or Tow
e Hosp		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
To th		Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 - 15 - 2010					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR MIRZA-ALIKHANI 11711 LIVINGSTON ROAD FT. WASHINGTON MD 20744								
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2. 2. 2016								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, 3 | 324 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Dean Duane Mulder September14, 2010 11:30 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3142 Gracefield Road Apt. 106 Silver Spring Prince George's Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Yrs. Director 515-24-7883 82 12/31/1927 Kansas Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Directo 1¥ Yes 2 No Maryland | Prince George's Silver Spring the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examination must be? 3142 Gracefield Road Apt. 106 20904 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐Yes 2 No Specify Specify: White 3 🗆 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Officer 0 U.S. Army 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Ira J. Mulder ဥ Hazel Ula Harper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3142 Gracefield Rd. Apt. 106, Silver Spring,MD 20904 Nancy W. Mulder/wife Department of Heal Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of Ar langton National Cemetery 20c. Location - City or Town, State 1√GBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/04/2011 | Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pulmonary Fibrosis resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) as the burial-transi Due to (or as a consequence of): Box 68760, physiciar death certificate be Physician/Medical attending IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ρ Month 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for Ö. ☐Yes 2☐No 9 Unknown 9 Unknown σ. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 certificate death? 2**X**X\0 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1XX\Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the

541

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Road, Silver Spring, Maryland 20904 Kundrat, M.D. 31. Date filed (Month

29c. License number

D0036716

29d. Date signed (Month, Day, Year)

September 14, 2010

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of State of Registrar	Maryland		artment of F <i>tificate of L</i>		d Mental Hy	giene Reg. No.	31325
	Physicia	an/	1. Decedent's Name (First, Middle, Last)			-		2. Date of De	ath	3. Time of Death
	Medi Examir	cal	Saundra Kay Mo 4a. Facility Name (if not institution, give street and number	etz_		45 O'T To 1			ber 17, 20	10 11:45 P ^M
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	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. las		If Under 1 Year Months Days		n (Month Do	h 9. E	Birthplace (State or Foreign
	Director		Usual Residence of Decedent	60	Yrs.			Dec. 6	1949 Per	Country) nnsylvania
	yland -f shov ed at	ctor	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	r 28a- notifi	Dire	Maryland Montgomery 10e. Street and Number		Dar	nascus			···	1 ☐ Yes 2X☐ No
:	with the 23a class Last be	eral	27620 Ridge Road			10f. Zip Code	872		10g. Citizen of What (Country?
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936	s after al", or Exami	Completed by Funeral Director	1 Never Married 2 Married 1 1 Sec. 2 If Yes, Give 1 Year or Date	₩ No	1	☐ Yes 2 🔀 No		rto riicari, etc./	Black, Wr	
9200-51212	'natur diral	olete	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	ent's Usual Occupa	ation		16b. Kind of Busines	White
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ם כ	Hygie Other rent, tl	Be	17. Father's Name (First, Middle, Last)			Bus Driv		ame (First, Middle,	Public Sch	1001s
yland	nd be n Menta arked atic ev	욘	Gene Merle Franks					ol Vanho		
Mar	shour hand 7 is m traum		19a. Informant's Name/Relationship (Type, Print)				nd Number or F	Rural Route Number	; City or Town, State, 2	
e,	f Healt item 2 other		Harold F. Metz - Husband 20a. Method of Disposition	20b. Pla	2762 ace of Dispos	0 Ridge ition (Name of	Road,	Damascus,	Maryland 20c. Location - City	
0 E	rage nent o ant: If Iry or		1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate cen	metery, crem	atory or other place		ľ	•	ia, Virginia
baitimore,	permit. Fage I and 2 should be filed within 72 hours after death with the Maryland death of Heath and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign lure of F) neral Service 1 icensee)	22. MC	Name and Addres	s of Facility	7/25/10	Funeral Ho	a, virginia
	10 = 10 0	. 8	23a. Part 1. Enter the disease, or complications that cau	mv sed the death						Ψ 20872
- p	nysician/		Immediate Cause (Final	line.	1	-		ic or respiratory arr	est,	Approximate Interval Between Onset and Death
	Medical xaminer		disease or condition resulting in death) a. Due to (or	as a consequer	nce of):	Cance				114
	.xummer	e.	Sequentially list conditions, b.	as a consequer						
Ited	d ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	as a consequer	nice oij.					
exec	physician and the burial-transit			as a consequer	nce of):					
icate be executed	physic s the b	ledical	d							
			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcor	me of pregnanc		Catalia and a			23d. Date of d	eliverv
Attending Physician: The law requires that the death certif	the att	Physician/N		nt at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
hat the	ned by the a detached i		Part II. Other significant conditions contributing to deat	n but not result	ting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
Juires 1	should be	Completed by						1 □ Y	es 2 No 3 □ I	Probably 4 🗆 Unknown
law re	has be	nple						24a. Was a		utopsy findings available completion of cause of
e Ti	certificate ha		25. Was case referred to medical					perfor 1 🗆 Yes		es 2 🗆 No
ysicia	is certi	To Be	examiner? Hospital:	atient 2 🗌 ER	B/Outpatient	Othor	ce of Death (Che		ence 6 Other (Spe	-:(-)
ing P	Viter th uneral		27. Manner of Death 28a. Date of it		Bb. Time of injury	28c. Injury work?	at		w injury occurred	city)
Attend	ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	niury - At home	e farm stree		es 2 □ No	205 1 10 10		
talor	rs after al Dire ed in b		4 ☐ Homicide determined 28e. Place of I building,	etc. (Specify)	c, iaiii, 31166	t, factory, office		City or Town	reet and Number or Ru s, State)	ırai Route Number,
Hospi	within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of	t examination ar	nd/or investig	ation in my opinion	death occurred	at the time date an	diplace and due to the	Caucala manage etated
To the	within To the comple		only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	ne best of my kn	nowledge, de	ath occurred at the	time, date and pl	ace, and due to the	cause(s) and manner as 9d. Date signed (Mont	s stated.
			Voseph m. Hass	ertyn	1.	D324	107		Sept. 20.7	2010
`	~		30. Name and address of person who completed cause of	death (Item 23	Ba) (Type, Pri		had	2000	0 4	
- (State	e S	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	7 10	1 med	ical (JKUK	Kockvill	P. MD 20854
	Registra		SEP 2 0 2010 ▶ ×	Alaskin .	1.	Bestel				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 9-27-10cr 10f.19b.PerSpouse Registrar Amend# s2.826.PerPhys.Amend10c.10eCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9-18-2010 Physician/ September McClure 9:32 A Ceci1 0swald Y 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Examiner 6202 Hope Drive Temple Hills 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 🔀 💥 M 2 🗆 F 0372471941 413-68-8624 Tennessee Yrs Director 69 Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Oxon Hill Prince George's Temple Hills Maryland 1 Tes 2 XXVo 10e, Street and Number 10f. Zip Code 20745 10g. Citizen of What Country? 7401 Oxon Hill Rd. Funeral 20748 6202 Hope USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1961-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates. ö þ 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 87 1 Yes 2 X No Specify: Black Specify. Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than 2 years Elementary/Seconday (0-12) U.S. Air Force Military ulth and Mental Hygie 27 is marked other r traumatic event, the other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph McClure Carol Collier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other train Temple Hills Maryland 7401 Oxon Hill Ro Janine McClure / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2 Cremation 3
Removal from State Greenwood Cemetery Department of Important: If any injury or once. 9/24/2010 Nashville, TN 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licensee ILL 20745 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 9 months Immediate Cause (Final Physician/ Recurrent Glioblastoma Multiforme Brain Tumor Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to large a parendument of cause. Enter Underlying Cause (Disease or iinjury burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) requires that the death in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 g Unknown signed by the a d be detached f 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably XX Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autops performed? Yes 2 XX the Hospital or Attending Physician: The Inin 24 hours after death.
the Funeral Director, After this certificate Inpleted filled in by the funeral director, page 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5-123 Residence 6 X Other (Specify) In-Law Resid Hospital 2 [X No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 14XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) MD 10200 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Priebat MD110 Irving Street N.W Washington, DC 20010 31. Date filed (Month, Day 32, Registrar's Signature State SEP 2 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. **Physician** Alzo M. McCain 19 2010 6:38A M /Medical 4a. Facility Name (If not institution, give street and number)
Bay Ridge Health Care Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 424-40-3912 Days Hours Min 1 M 2 □ F 75 Director July2,1935 Alabama Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at Md. P.G. Director Bowie 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12314 Quarterback 20720 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23; any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Truck Driver 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert McCain Samuel Rosie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice L. McCain Wife 12314 Quarterback Court Bowie Md. 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery Sept.25,10 Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wash.D.C. Robinson Funeral Home 1313 do 23a. Part1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiorespiratory arrest /Medical Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2: performed: certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending 1 🔀 Natural 5 ☐ Pending investigation Injury thin 24 hours arter to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

To the within

Division or Vital Records, P.O.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kurup, MD

and manner stated.

Bay Ridge Health Center Annapolis, Md.

29c. License number

D0063681

29d. Date signed (Month, Day, Year)

Sept. 21, 2010

31. Date filed (Month, Day, Year) SEP 2 2 2010

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 20 ŽÕ10 Douglas Stephen McHale 7:05 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House - Montgomery Hospice Derwood Montgomery 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 25 Funeral 9. Birthplace (State or Foreign Days Hours Min ^{Yea}1953 **Director** 204-44-0978 57 Yrs Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MDMontgomery Rockville 1 X Yes 2 □ No 10e, Street and Number ō 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 13115 Ardennes Avenue 20851 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Forces? Yes 2 No 1977-Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1981 1 ☐ Yes 2 🎇 No Specify: White 3 Divorced 4 Divorced Specify: Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other thar event, the M Hudson Trail Outdoor Elementary/Seconday (0-12) College (1-4 or 5+) Sales Outfitter 5+ Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene McHale Beatrice Shore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Dominguez / Spouse 13115 Ardennes Avenue, Rockville, MD 20851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State eptember 20, 2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signature of Funeral Servic 22. Name and Address of Facility 1 Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 M01117 DeVol Funeral 1 RAG 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-tensit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should to 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 X No 1 \sum Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 💢 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 D Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

+

Jocelyn Kouatchou, M.D., 6001 Muncaster Mill Road, Derwood, MD 20855

Registrar's Signature

163748

September 20, 2010

· Moual the u

21 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C911 1/05/2011 The State of Maryland 7 Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1205 Physician/ Month ,2010 Sept.17 Olga G. McClure Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 099°16'-254" 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 372371923 87 New York Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Bethesda 1 ☐ Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral 6204 Rockhurst Road 20817 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2 🗗 No Specify: If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Editor College (1-4 or 5+) Elementary/Seconday (0-12) Publications of the and Mental Hygier 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Gallik Suzana Witek permit. Page 1 and 2 should be Department of Health and Meni Important: If Item 27 is marke any injury or other traumatic , once. ^{19a.} Informant's Name/Relationship *(Type, Print)* Brooks McClure/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 Rockhurst Road Bethesda, Maryland20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 9/21/2010 Beltsville, Md 4 Donati 5 Other (Specify) 21. Signatu PHNETE INPADES RENIALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the I lseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Metastatic cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Atherosclerotic Cardiovascular Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the f.meral director, page 2 should I . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Management 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work' 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 🗆 (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month. Dav. Year) who completed cause of death (Item 23a) (Type, Print) 8600 30. Name and address 8600 Old Georgetown Road Bethesda, Md 31. Date Regis State back

Registrar

21

17,2010

September

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ Jeffrey Franklin Matthews eptember 29 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Regional Med. Center Cumberland 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🕅 M 2 🗆 F Months Hours (Month, Day, Year) 10/12/1968 Mary Land 41 219-88-4057 **Director** Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City. Town or Location 10d Inside City Limits Director MD Allegany Corriganville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10808 Kreigbaum Road USA 21524 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Š 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes Give Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Clerk Retail permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ William Franklin Matthews Virginia Lois Garlitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois V. Matthews/ Mother P.O. Box 34, Corriganville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Restlawn Mem. Gardens 10/02/2010 LaVale, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: ည 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of celtifier 29c. License number 29d. Date signed (Month, Day, Year) D0033280 Sept 29 2010 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue, Cumberland, MD Sunil K. Gupta, M.D., TIRS 21502 31. Date filed (Month, Day, Year) SEP 30 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Elizabeth Malloy Medical 09 2010 12:00 pm 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 704 North Bend Road Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD **Funeral** 8. Date of Birth 1 □ M 2 □ 🕏 Months Days Hours Min 212-24-1194 Director 87 03/ Usual Residence of Decedent or 28a-f show notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It is a 27 is marked other than "natural", or items 23a or 28a-f shoof item 27 is marked other than "natural", or items 23a or 28a-f shoof item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified as 10c. City, Town or Location Director 10d. Inside City Limits MD **Baltimore** Towson 1 Yes 2 Xio 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 704 N. Bend Road 21204 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Specify Completed white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Microbiologist Health Department To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward F. Mullan, Sr Anna M. (Bishop) Mullan permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print)
Karen Malloy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 704 N. Bend Road Towson MD 21204 Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. MD Cresaptown 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Scarpelli Full eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Onset and Death disease or condition resulting in death) Medical Examiner Kinson Sequentially list conditions, if any, leading to him rediate cause. Enter Underlying Cause (Disease or linjury Examiner been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been si funeral director, page 2 should be 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospita 2 🔀 No Other 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending neral Director: A Ifilled in by the f 1 Tes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #/02 TOWSON, MD KAREN 7901 31. Date filed (Month, Day, Year) 32. Regis rar's Signature State Registrar DHMH 17 Rev 7/2009 ORIGINAL

only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** September 12, Thomas 2010 Richard Nikels 9:00 P. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) Nov. 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 X M 2 □ F Months Days Hours Min Director 140-22-9254 1928 Usual Residence of Decedent permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28e-f show any injury or other traumatic event, the Michael Exteriment materials. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1XYes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Russell Avenue, by Funeral # 404 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1⊠Yes 2 No 1951If Yes, Give Year or Dates: 1953 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗙 No Specify Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manager Trave1 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ John Nikels Denutis Eva 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Whitney Coe/Partner 403 Russell Avenue, # 404, Gaithersburg, MD. 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔣 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Cross Cemetery 9/28/2010 North Arlington, NJ 22. Name and Address of Facility DeVol Funeral Home 21 Sex ure of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death M. muttu Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Pregnant at time of death Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medic examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year)

21 2010

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ RUSSELL AVENUE
LL RUBERT BIRSCHARILL MIN CONTRACTOR OF THE PROPERTY O IL ROBERT BIRSCHBACH, M.D.

20

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 31334 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Loretta Iris Nield М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/23/1914 **Funeral** 9. Birthplace (State or Foreign Months 1 🗆 M 2 ⋤ F Hours Director 220-10-4406 96 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 911 Lexington Avenue death with 21502 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Practical Nurse Infirmary other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental fitem 27 is marked ဂ္ George Nield Bessie Amelia Fauble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Smith / Nephew 303 Champlain Road, North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Park 10/05/2010 Cumberland, MD 21. Signature of Funeral Service Line 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final ESPIRATOR Ph sician/ disease or condition Medical Examiner resulting in death) とかも Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ō Pregnant at time of death the. cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 1 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 🗌 Yes Accident Investigation within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ٥ 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 4865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

200 Glenn Street, Cumberland, MD

21502

Robustiano J. Barrera, M.D.,

31. Date filed (Month, Day, Year)

SEP 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Llovd R. Nave Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland WMHS-RMC Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Dec 6 PA Director 182-14-8597 87 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director PA Bedford Bedford 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 885 Centerville Road 15522 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give WWII Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Dairy Farming Farmer Be and 2 should be filed Health and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Edgar R. Nave Jennie G. (Tewell) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 885 Centerville Road Bedford 19a. Informant's Name/Relationship (Type, Print) PA permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ramona Nave Wife 15522 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cem 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/28/2010 Bedford PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility eral Home 214 S. Juliana St.; Bedford, PA 15522 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate has performed? 1 Yes 2 No 2 No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra s Signature State Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registra Amend #10g. Per FHPGC9-28-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Florence Ologo 4:55 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Sprin عفنه , MD Montgomery Center Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 🖾 F 385-13-3818 January 1926 |Somanya, Director 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show traumatic event, the Medical Examinar must be notified at 1KYes 2 □ No Director MD Montgomery Silver Spring 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Ghana 922 Good Hope Drive 23a 20905 -USA Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2⅓∑ If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 21K No Specify: Black Specify. 2 3 Widowed 4 □ Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) 3rd College (1-4or 5+) filed within Hygiene. Private Trader Entrepreneur s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emmanuel Kwame Nartey Mary Abena Odentewaa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Victoria Aryeetey - Daughter \$22 Good Hope Drive, Silver Spring, Maryland 20905 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 K Removal from State SRA Presby Memorial Cemetery 12/04/2010 Somanya, Ghana 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Sort 716 Kennedy Street, NW, Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CVA disease or condition resulting in death) 2 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed Pnou burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
g ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed t I be deta 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 2 1 ☐ Yes 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0.0 9/17/10 H67624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3227 mD, Sultana Afrooz, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2010 Registrar

DHMH 17 Rev 1/2001

10-07446 David Olson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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23b. Was decedent pregnant in the past 12 months? Composition Compo	-
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the underlying cause given in Part I. 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause 1	-
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24a. Was an autopsy find prior to completion death? 1	Unknown
Describe how injury occurred 1	
25. Was case referred to medical examiner? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Ves 2 No 28d. Describe how injury occurred 1 Ves 2 No 28d. Describe how injury occurred	No
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2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route	
	umber, City
28. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Suicide Suicide Homicide Could not be determined Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yilliam)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yill) O.C.M.E. September 28, 2010	ar)
30. Name and address of person who completed cause of death (Item 23a)	
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day Year) 32. Registar's Signature Registrar 100 0 6 20 0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 5, 2010 Physician/ 5:55 JEANNIE SUE PARKER Рм Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Frederick 106 Locust Drive Thurmont 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours Min. Octonth, Pay, Yga961 Kentucky 48 317-72-3244 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 ☐ No Frederick Thurmont Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral U.S.A. 21788 within 72 hours after death with 106 Locust Drive or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours treent of Health and Mental Hygiene.

Trant: If item 27 is marked other than "natur rant: If item 27 is marked other than "natur. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Packer Moving Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loula May Imbody Andrew Eugene Hamm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Locust Drive, Thurmont, Maryland 21788 Carolina O. Parker / Daughter 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Department of Important: If any injury or once, Sunset Memory Garden 9/18/2010 Parkersburg, WV 4 Donation 5 Other (Specify) 21. Signature of Femeral Service Linesee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET. THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SMAU CELL LUNG CANGER Physician/ MONTHS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of use as the burial-transit requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknow 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1/X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No 1 ☐ Yes 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2/No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 욘 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Hospital or Attending 5 Pending injury death. Accident 1 ☐ Yes 2 ☐ No Investigation after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature 2010

DHMH 17 Rev 7/2009

State

Registrar

501

REDERICK MD

21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O'CONNOR

32. Registrar's Signature

BRIAN

31. Date filed (Month, Day, Year)

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	-		Registrar 1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea	ath	- U 1 U -	3. Time	of Death
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	<i>'</i> .		Montgomery Hos			. 4 1- 411 3	Roc	ckvill	ender 24 Hrs.	8. Date of Birt	Montgomery Birth 9. Birthplace (State or Foreign			
	Funeral Director		5. Social Security Number 579–30–0534	6. Sex 1 X M 2 □ F	7. Age (In yrs. I: 83	Yrs.		Days Hou		(Month, Day	y, Year)	Cour		or Foreign
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	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	11. Mantal Status	12. Was Dece	dent Ever in U.S	S. 13. \			Origin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ameri		
9	fter de , or it amine	þ	1 Never Married 2 Mar	ried Armed For	ces? 2 No 2 45-	16	Yes, specify			Hican, etc.)		Black, White,	_{etc.} ack	
8	iurs at tural" al Exa	Completed	3 Widowed 4 Divorced	Teal Of Da	tes. 43-									
15	72 ho n "nat	nple	(Specify only high	nt's Education est grade completed)		(Give	dent's Usual C kind of work o O NOT use re	done during I	most of worki	ng	16b. Kii	nd of Business In	dustry	
712	within giene. er than		Elementary/Seconday (0-12)	College (1-			ninistr			ľ	atic	nal Sec	urity	Agency
ď	should be filed within 7, and Mental Hygiene. is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, I	Last)				18. N	lother's Name	e (First, Middle,	Maiden S	Surname)		
ylaı	uld be file Mental narked c	2	Julian Shakes	peare Patt	erson			L	olita_	Banks				
Maryland 21215-0036	shoun and 7 is m		19a. Informant's Name/Relations									Town, State, Zip		
	and 2 Healtl em 2 ther t		David M. Patte: 20a. Method of Disposition	rson/Son	20h F	13220 Place of Dispo			1	r Sprin		ryland cation - City or T		
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State C	emetery, crer	natory or othe	er place)						
Ħ	nit. Partme lartme lortan injur.		21. Signature of Funeral Service I	_icensee	- A-1111	ryland	2. Name and A	Address of Fa	acility			tenham,		na
ä	permit Depar Impor any in		Dany.	N. C.r.	all	140	Henr	cy S.	Washin	gton &	Sons	Co.,Inc	C 20	019
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that controls one cause on each	aused the deat	h. Do not ent	er the mode o	f dying, such	h as cardiac c	r respiratory an	est,	119001175	Approximation Interval Be	ate
	Physician/		Immediate Cause (Final disease or condition			Heart	Digos	20					Onset and	
7	Medical Examiner		resulting in death)	Due to (c	Stage or as a consequ	uence of):	171.3.21.							
	Zxammor	er	Sequentially list conditions,		ial Fik		ion	_						
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (t	or as a consequ	derice on.								
	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of):								
0	e be exe ysician ie burial	lical		L d										
9249	eath certificate b attending physi I for use as the b	Physician/Medi	IF FEMALE:	T										
9 X	ith cer ittendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregna Birth 2 - Feta ant at time of a	aldeath 3	Ectopic pre				1	23d. Date of deliv Month	ery Day	Year
Box	e dea the a	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unkn		Jean 3L	1 Other (spec	···y/						
P.O.	hat thed by	y Pr	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the u	inderlying cau	ıse given in f	Part I.	23e. Did to	obacco us	se contribute to t	he cause of	death?
	uires i n sigr	q pa	Mitral_Val	ve Replace	ment					1 🗆 '	Yes 2	□ No 3 □ Pro	bably 4 🔀	Unknown
Ö	w req	plet	Aortic Val	ve Replace	ment					24a. Was autor		24b. Were auto	psy findings mpletion of	available cause of
Rec	The la ate ha bage (Completed by								perfo	rmed?	death?		
ā	cian: ertific ictor,	Be (25. Was case referred to medical examiner?	Lleavital		-		T .	Death (Check	only one)				
Ž	Physic this o	<u>0</u>	1 Yes 2 X No 27. Manner of Death	Hospital:	inpatient 2	ER/Outpatier						Other (Specify	Hosp:	ice
n 0	ding F h. After funer	Certificate:	1 🔀 Natural 5 🗌 Pendir	ng (Monta	h, Day, Year)	injury	M 28c.	Injury at work? 1 Yes	_	28d. Describe h	iow injury	occurred		
Sio	Atten r deat ctor: by the	rtific	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ho							Number or Rura	l Route Nun	nber,
Division of Vital Records,	al or safte	I Ce	4 🗆 Hornicide deterni	buildin	ig, etc. (Specify)				City or Tow	n, State)			
_	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical I	Physician: To the be xaminer: On the basi	s of examination	n and/or inves	tigation, in my	opinion, dea	th occurred at	the time, date a	nd place,	and due to the ca	iuse(s) and m	nanner stated.
	the hin 24	Me	only one) 3 Certifying	Nurse Practioner:	o the best of m	y knowledge, o	death occurred	at the time,	date and place	e, and due to the	e cause(s)	and manner as s	tated.	
	5 wild		29b. Signature and title of certified T. Louce	Jehou,	WD			637				e signed (Month, /20/10	⊿ay, rear)	
	MIVA		30. Name and address of person		of death /Item	23a) /Tvne 5			-1 0			7 . 0		
7	シン		Jocelyne Kou					ill Ro	ad, Ro	ckville	, Mar	ryland 20	0855	
4	Stat		31. Date filed (Month, Day, Year) SEP 2 2 201		egistrar's gna									
	Registra	ar	3EF & Z 201	cerany	1 p. 1	gara								

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State of Maryland / Department of Health and Mental Hygiene

lustin Pannell		State of Maryland / Department of He -For State Certificate of De			2010	31340
Physiciar Medical Examin	1/	Registrar 1. Decedent's Name (First, Middle, Last) Justin Terrell Pannell		Date of Death Month September		3. Time of Death 1340 hrs
medical Examini	G1		ity, Town, or Location of Dea		4c. County of Death	
· ·			heverly Under 1 Year If Under 24H	To D-t	Prince George	
Funeral Director		219-43-5107 _{1XM 2F} 15 Yrs. M	Under 1 Year If Under 24H Ionths Days Hours M		3, 1995 Co.	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1.5			10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ត្ន	Maryland Prince Georges Capitol Hei	· · · · · · · · · · · · · · · · · · ·			1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	210 Daimler Drive 20	7. Zip Code 1743		g. Citizen of What Coun	
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shural mater of the Medical Examiner must be notified at one	Funeral	1 Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? (pecify Cuban, Mexican, Puer 2 No specify:		14. Race - Americ White, etc. B1a Specify:	
ours after	ē ē	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Ut	sual Occupation (Give kind o		16b. Kind of Business/Ir	ndustry
36 in 72 hc han "ng lical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Stud	f working life. DO NOT use re ent	etirea)	Public	Schoo1
15-003 filed withi Hygiene. d other th	<u>ا</u> ق	17. Father's Name (First, Middle, Last)		ne (First, Middle, M	·	
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	å	Dave Orville Cobrand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	Melis		etta Pannel	
MD 2 d 2 shoul tth and M n 27 is m numatic] ۵				H ei ghts, Md	
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and I Important: If item 27 is r injury or other transmit		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition crematory or other placements of the place of Disposition crematory or other placements.	(Name of cemetery, lace)	Date	20c. Location - City or 2010 Wald	Town, State lorf, Md.
Baltir Sermit. I Departm Importa njury o	j	21. Signature of Funeral Service Licensee	and Address of Facility W. 7 14th Street	H. Baco	n Funeral H Washington,	Home, Inc.
Physician /Medical	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the more failure. List only one cause on each line.				Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):		_		Death
	<u>ا</u> ةِ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
- · · · · ·	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
50, te be executed ysician and burial - transit	ledical E	d			·	
760, cate be physici	Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		-, -, -,	23d. Date of delivery	
Box 68760, e death certificate be the attending physici ed for use as the buri	Physician/N	past 12 months?	eath 3 Ectopic pregr	nancy	Month D	ay Year
that the de		Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
s, P.O nires that t	g g				2 ✓ No 3 Prob	
of Vital Records, P ig Physician: The law requires t the this certificate has been sign neral director, page 2 should be	Completed			24a. Was ai autops perform	y prior to co	opsy findings available ompletion of cause of
tal Rec		25. Was case referred to medical	26.Place of Death (Chec	1 Yes 2	No 1 ✓ Yes	2 No
Vital ysician his cert	e Re	examiner? 1 Vyes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3	Othor		tesidence 6 Other:	
tendir sath.	ation: I	27. Manner of Death 1 Natural 5 Pending Power of New York Sep 7, 2010 28a. Date of Injury FOUND: Sep 7, 2010 28b. Time of Injury FOUND: Sep 7, 2010 28b. Time of Injury FOUND: 22100 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe ho Subject shot	ow injury occurred	
Division Division ours after death. teral Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined Copecify Local Street 28e. Place of Injury - At home, farm, street, fact (Specify) Local Street	ctory, office building, etc.		reet and Number or Rur ate) block of Central Aver	
8 - 2	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	t the time, date and place, ar n my opinion, death occurred	nd due to the cause at the time, date a	(s) and manner as state nd place, and due to the	d. cause(s)
To with	ğ	29b Signature and title of certifier	29c. License number		29d. Date signed (Mon	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		September 9, 201	· · · · · · · · · · · · · · · · · · ·
R2		Victor Weedn MD JD Assistant Medical Examiner 111 Penn	Street, Baltimore, MI	O 21201		
Stat Registra	~	31. Date filed (Month, Day, Year) SFP 2 2 2010 Same A. Sauce				
DHMH 17 Rev 1/200)1	OCIAE ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Pfitzenmayer Kathryn Fave Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Western MD Regional Medical Center 8. Date of Birth (Month, Day, Year) 08/18/1950 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 🗆 M 2 👽 F Country) Maryland 60 Director 219-54-1809 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director Oldtown 28a-f MD Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral USA 21555 17911 Oldtown Road, 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify. Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse's Aid Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin ൧ Boyer Ruby Eulla Pershing Hugh injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17911 Oldtown Road, SE, Oldtown, MD Edward Pfitzenmayer / Husband 1 and 2 s of Health item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 【☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Mem. Gardens 09/23/2010 LaVale, MD Adams Family Funeral Home, 22. Name and Address of Facility of Funeral Service Licenses 21502 404 Decatur Street, Cumberland, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a cons Examiner e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed -transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) inding physician ause as the burial. Physician/Medical P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No
9 Unknown ō Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 Yes 2 No After this certification, it 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 X No 1 Nation 2 ER/Outpatient 3 DOA ٥ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending Natural within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 🗌 No Accident
Sufcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, To the I within 2.

MAL

30. Name and address of person who completed eause of death (Item 23a) (Type, Print) Nagaratnam A. Ranjithan, M.D., 517 Oldtown Road, Cumberland, MD

State Registrar 31. Date filed (Month, Day, SEP 21 2010

29b. Signature and title of certify

29d. Date signed (Month, Day, Year)

21502

2010

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			For	State of	Marylar	nd / Depa	artment of F	lealth a	and Me	ental Hygie	ne			
			State Registrar			Cer	tificate of L	Death		Reg.	Ng2 0	0	31	342
	ysicia Medic		1. Decedent's Name (First, Midd. Helen	e, <i>Last)</i> Delore	:s	Ped	ck			2. Date of Death Month	Pay Y	aar	3. Time (of Death
	kamin		4a. Facility Name (if not institution	. •	*		4b. City, Town, or	f Death		4c. County of		200		
المر			Western MD Reg					mberl				egany		
	neral ector		5. Social Security Number 217–28–9522	6. Sex 1 □ M 2 ☐ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Yea 10/27/193	ar)	Country	ice (State () ylan(or Foreign d
pu wod	at	or	Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	ty, Town or Lo	cation					10d	d. Inside (City Limits
Maryla	otified	Director		llegany		Cumbe	erland						1 🔀 Y6	es 2 🗆 No
with the	ust be r	Funeral D	10e. Street and Number 247 Columbi	a Street			10f. Zip Code	1502		10g.	. Citizen of Wha USA	at Country	/?	
21215-0036 within 72 hours after death with the Maryland eit than "natural", or items 23a or 28a-f sho	any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☒ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If You Give	s? X No	l	Was Decedent of Hi f Yes, specify Cuba □ Yes 2 💢 No	n, Mexican,			14. Race - , Black, \ Specify:	American White, etc).	
15-C 2 hou "natu	edica	plet		ent's Education est grade completed)		(Give I	lent's Usual Occupa	ation during most	of working	166	b. Kind of Busin	ess Indus	stry	
2121 within 7 giene.	t, the M	• Completed	Elementary/Seconday (0-12)	College (1-4	or 5+)	1	onoruse retired) sing Assi	stant			Hospi	tal		
Maryland 21215-0036 2 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", o	tic even	To Be	17. Father's Name (First, Middle, Thomas	C.	F	Peck		18. Mother Eli:	r's Name (F zabet	First, Middle, Maid h	den Surmarne) Ovelto	on		
d 2 shoul sath and 1	er traum		19a. Informant's Name/Relations Gerard A. Pec				g Address (Street a Columbia					e, Zip Cod 2 1 50	_ ′_	
Baltimore, permit. Page 1 and Department of Heal moortant: If item	ry or oth		20a. Method of Disposition 1 ፟ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ate c	emetery, cren	sition (Name of natory or other places Cemeter		Dat		Cumberl			
Baltimo permit. Page Department Important: I	any inju once.		21. Signa ure f Funeral Service		DU.	22	. Name and Addres	s of Facility	Adam	ns Family	y Funer	al Ho		P.A.
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that cau only one cause on each	sed the deat line.					_	1114, 112	A _l	pproxima	etween
	dical		Immediate Cause (Final disease or condition resulting in death)		as a consequ			ire				+	nset and	Death
Exam		ner	Sequentially list conditions, if any, leading to immediate		as a consequ		ident]	Dial	oete	es Mel	litus			
be executed sician and	-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. — Due to (or:	as a consequ	lence off:								9
760 cate be executed physician and	he buria	edical		d						-				
certificate adding phys	e as t	₩	IF FEMALE:	23c. If yes, outcor	no of process						T			
Box death re atte	ched for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birl 4 Pregnar 9 Unknow	th 2 🗀 Feta it at time of c	ıl death 3 🗌	Ectopic pregnance Other (specify)	у			23d. Date of Month	f delivery Da	ıy	Year
DIVISION Of VITAL RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the	d be detad	þ	Part II. Other significant conditi	ons contributing to deat	h but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did tobacc	co use contribut			
Vital Kecords, ysician: The law requires is certificate has been sig	2 shoul	Completed								24a. Was an autopsy	24b. Were		findings	available
The la	r, page									performed 1 Yes 2	?, deat	h? Yes 2[Cause of
/Ital siciar certif	irecto	m ,	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			Othe	r: Death						
n OT V ing Phy ifter this	uneral d	ate: To	27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of i		ER/Outpatien 28b. Time of injury	28c. Injury	4 ∐ Nur		e 5 Residence d. Describe how in		pecify)		-
DIVISION OT tal or Attending Pr 's after death. In Director: After th	n by the f	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e, Place of	Injury - At ho etc. (Specify,	me, farm, stre	M 1 1	Yes 2 1	_	f. Location (Street City or Town, Sta		Rural Ro	ute Num	ber,
Spital or nours a	i filled i		29a, Certifier 1 Certifying	Physician: To the best	of my knowl	edge, death o	ccured at the time.	date and pl	ace, and d	due to the cause(s)	and manner as	stated		99
the Ho thin 24 I	mpletec	Medical	(Check 2 Medical I only one) 3 Certifying	xaminer: On the basis on Nurse Practioner: To t	f examination	and/or investi	gation, in my opinior eath occurred at the	n, death occ time, date a	urred at the	e time, date and pla and due to the caus	ace, and due to se(s) and manne	the cause(r as stated	d	anner stated.
3	- 1		29b, Signature and title of certifie	to 5 mg			29c. License	_	26	29d. I	Date signed (Mi	onth, Day,	, Year)	
	RS		30. Name and address of person	ertz MD.	f death (Item	23a) (Type, Pr	int)	HWY	Lav	Vale, M	D 21	506	2	
Reg	State gistra		SEP 1 7 2	010 Sens	strar's Signat	yare	red .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 16, Year 2010 ROSA B. PATRIZIO 4:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WILLIAM HILL MANOR EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🗶 F Hours 97 NOOnth, Day, Year 912 PENNSYLVANIA Director 204-03-3386 Usual Residence of Decedent item 27 is marked other than "natura", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits EASTON MARYLAND TALBOT 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 501 DUTCHMANS LANE APT 323 21601 UNITED STATES be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2X No Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 **SECRETARY** GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ DOMINICK BONELLO TERESA PAVIA Page 1 and 2 should of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANGELA SMITH/DAUGHTER 1305 OYSTER COVE DRIVE, GRASONVILLE, MARYLAND 21638 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State SEPT^{Date}17 permit. Page 1 a
Department of I
Important: If ite
any injury or ot CHESAPEAKE CREMATEON 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CENTER STEVENSVILLE, MARYLAND Signature of Funeral Service Licenses FEETOWS, HECFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) unresponsiveness Own Medical Due to (or as a cons quence of): Examiner 106,618 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by the attending physician tached for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypothyroidism Completed 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Cerebral Arthersclerosis 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' 24 hours after death. E Funeral Director: After this certificate Diabetes Mellitus 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 XNo 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number R077623 Listen CRUP

Registrar
DHMH 17 Rev 7/2009

State

545 Cynwood

32. Registrar's Signature

Drive Easton,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31344 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Q** Physician/ 15 Day 2010 Micheal William Paal 1:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Wicomico Nursing Home Salisbury If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Month, Day, Year 9/15/1915 1 🛛 M 2 🗆 F Days Min Director 190-09-6390 95 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Worcester Snow Hill 10f. Zip Code 10g. Citizen of What Country? by Funeral 200 West Federal St. 21863 USA within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 No 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) / Operator Florist Be traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F is marked of ည Page 1 and 2 should be John Paal Rosie Bordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 7627 Belona Ave., Baltimore, MD 21204 Rutland B. Paal / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. 9/21/2010 Timonium, MD 21. Signature of Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 28111 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Stroke Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 X After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29c. License numbe 29d. Date signed (Month, Day, Year) D60515 9/21/2010

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Mahesha Thimmarayappa M.D. 910 Eastern Shore Dr., Salisbury, MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sep 1 Physician/ : 55 AM aro Medical Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Washinston Medical Ctr Arunde Burnie Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day Y Jan 17) 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) Funeral Year 1966 1 🗆 M 2 🛱 F Yrs. Director 212-88-5782 44 Usual Residence of Decedent or 28a-f show Examiner must be notified at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Anne Arundel Severn Maryland 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral death with 21144 United States 8208 Consett Court "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: **Black** Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Housekeeper Private Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph L. Stevenson Carol Rice permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonio Parker - Husband 8208 Consett Court Severn, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 24. Harmony 4 Donation 5 Other (Specify) Landover, Maryland 22. Name and Address of Facility of Funer | Service License Stewart Funeral Home, 4001 Benning Road NE Washington, DC 20019 Part beter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence bij: Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? o Month Day Year detached 9 🗆 Unknown g Unknown P.O. signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ercholesterolemia Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ၉ 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Sept. 16, 2010

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7551. Teaque Road, Suite 210, H

32. Regis

field

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT Year 1010 FLORENCE LAVERNE Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medicar NICINICO TENINSULA REGIONAL SALISBUM Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🌠 Months Days **Director** Usual Residence of Decedent 28a-f show 10a. State ıral", or items 23a or 28a-f shor Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TYASKIN 1 Yes 2 No WICOMICO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4648 TYASKIN 1865 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 \square Never Married 2 \square Married þ 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 "natural", 1 Yes 2 No Specify. 3 XWidowed 4 ☐ Divorced Completed NHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 40MEMAKER OWN HOME permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important; if item 27 is marked othe any injury or other traumatical once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ZADA ENNETH 49. THUFF STULAIR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720THWELL(SOD CHALESTOWN-NEW HEART INVI Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Weurial 2 Cremation 3 Removal from State CEMETER! 4 Donation 5 Other (Specify) TVASKIN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cr/Enn resicher 23a. Part Liter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death omolica bas Physician/ disease or condition resulting in death) Medical Examiner ASCUD Sequentially list conditions Examiner in any, leading to immediate cause. Enter Underlying Due to (or as a consequence or, as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? autopsy performed? this certificate 1 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 🗌 No Other: ✓ Inpatient 2 □ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the non-within 24 hours after deau.. To the Funeral Director. After thi Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred □ Natural 5 Pending 2 Accident 9/17/10 0 800 +all Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the dest of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Murse Praydoner to the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title 29d. Date signed (Month, Day, Year) OME H0059368 SEPT. 18 2010 diffess of person who completed cause of death (Item 23a) (Type, Print) Christophen Snyden DO DME, John Visioli DO 100E CAPROLIST St. SALISBURY Md 2180 31. Date filed (Month, Day State 2 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, L	eilly			4b. City,	Town, or	Location o	of Death	2. Date of Deat	Day	Year	3. Time of Death 8:45A M
		iei	7918 Belgaro Roa	ad	(In vrs.	last birthday)		aure			8 Date of Birth		Monte	gomery
	Funeral Director		579-42-9720 Usual Residence of Decedent	1□ M 2 X F	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Jan • 7	Year) 1934	Was	thplace (State or Foreign ountry) shington, D.C.
	a-f show	ctor	10a. State 10b. County	gomery	10c. Cit	y, Town or Lo Rockv			• -					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	h with th	al Dire	10e. Street and Number 13809 Sloan Stre	et			10f. Zip	Code	2085	3	1	_	n of What C	•
036	172 hours after death with the Maryland "neturel", or Items 23e or 28a-f show offed Exter there's ast be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		Race - Am Black, Whi	·
Maryland 21215-0036	S 2 3	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5		16a. Deced (Give life. L	dent's Usua kind of wor DO NOT us	k done d	urina most	of workir	ng	16b. Kind	of Business	/Industry
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altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 [14 ☐ Donation 5 ☐ Other (Speci			lace of Dispo emetery, cren tropol:				9/16				Town, State
Balti	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Lice	•	1		Name and Muri	d Address	s of Facility Bar	ber	Funeral Laytons	Home	2	
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Vital Records,	The ate h page	Completed	Coronary	arteridism	40	1.30	956	2			24a. Was ar autops perform 1 Yes 2	y	24b. Were a prior to death?	utopsy findings available completion of cause of 2 No
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Division of	Attending P ir death. actor: After t by the funera	atlon;	27. Manner of Peath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	M 28	Bc. Injury Work' 1 □ Y	at ? 'es 2 □ N		8d. Describe ho	w injury o	ccurred	
Divis	Pir Pir	Certification;	3 Suicide 6 Could not to 4 Homicide determined		ry - At ho . (Specify	ome, farm, stre	eet, factory,	office		2	8f. Location (Str City or Town		lumber or R	ural Route Number,
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	To the within 2: To the complet	M	29b. Signature and title of certifier	n 1-		10		License		/	29	d. Date s	igned (Moni	th, Day, Year)
7	9		30. Name and address of person wh	completed cause of de	eath (Item	23a) (Type, I			604		, 1	7	1101	10
	15 Sta	te	31. Date filed (Month, Day, Year)	CO M D 32. Registra	r's Signal	LSeve ture	1	00	CS K	vac	1, Ro	atti	Ville	MD20354
	Registr	ar	SEP 20	1 2070 Les	LI GANE	1 10	BOOK	Carlo						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2010 Ronald Keith Roberts 04:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 830 East Old Philadelphia Road E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 XM 2 🗆 Hours Min Director 1965 Pennsylvania 45 203-48-7872 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the interpretable and Mental Hygiene.
Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 830 East Old Philadelphia Road 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Plumber</u> Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Roberts Carol Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karon B. Roberts / Spouse 830 East Old Philadelphia Road, Elkton, Maryland21921 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East Cemetery Methodist Cemetery 25, 2010 North East, Maryland 21. Signature of Fun al Vrvi icens 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician disease or condition Medical resulting in death) **Examiner** sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and the burial-trar Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Month Year 5 Other (specify) 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural work? 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Ortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) H0057173

State Registrar 30. Name and address of

871

31. Date filed (Month, Day, Year)

#3)4

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Huzefa Bahrain

BALTMONE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enesis Romer		State of Maryland / Departr 1- For State Certifi	ment of <i>icate of</i>		d Mental		a No 2010	31349			
Physicia		Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Modth Day Year									
ledical Exami	ner	Genesis Romero 4a. Facility Name (if not institution, give street and number)		b. City, Town, or	Location of Do	Septembe	er 18, 2010	1409 hrs			
		Holy Cross Hospital	"	Silver Spring		atri	Montgomen				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday)	If Under 1 Year	If Under 24h	Irs. 8. Date of Bir	th (MM/DD/YYYY) 9.	Birthplace (State or			
Director		216-87-2649 1□M 2XF	Yrs.	Months Days	Hours N	1in. 03-17-	·2010	eig Mar yland Country)			
'n		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov	ım ar l agati					10d. Inside City Limits			
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nylanc ta-f sh	ctor	MD Prince George Adel	Lpni	10f. Zip Code		11	0g. Citizen of What C				
the Ma n or 28	Director	8910 Trapper Lane		20783			U.S.A.				
ms 23.	eral	11. Marital Status 12. Was Decedent Ever in U.S.				Specify Yes or No		nerican Indian, Black,			
r death or ite	Funeral	1 Yes 2 No									
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland (ealth and Montal Hygiene, man "natural", or items 23a or 28a-f she trem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	To B	Oliver Osmany Hernandez 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing			oemy Rome	ETO nber, City or Town, Sta	ate, Zip Code)			
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is m injury or other traumatic.							ryland 207				
re, les land freel freel freel freel freel freel freel freel free free			e of Disposit	tion (Name of cerr er place)	netery,	Date	20c. Location - City	or Town, State			
Page Page nent o			Ly Cem	etery	09-	-27-10	El Salva	dor			
Baltimore, permit. Pages I at Department of He Important: If ite		21 Signature of Funeral Service Licensee CC 0518	22. Na	ame and Address	of Facility W	H. Bacor	Funeral	Home, Inc.			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do					ston, DC 20	OOTO Approximate Interval			
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia						Between Onset and Death			
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Box 6876C e death certificate the attending physed for use as the br	iciar	past 12 months? 1 Live birth 4 Pregnant at time of death	- =	aldeath 3 <u>[</u> er (S <i>pecify)</i>	Ectopic preg	nancy	Month	Day Year			
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Vital I hysician: this certifi al director,	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/	Outpatient		\thear =		Residence 6 Ott	ner:			
Division of Vital Records, To the Hospial or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	i.	27. Manner of Death 28a. Date of Injury 28b.	o. Time of Inj		at Work?		now injury occurred ped between be-	d and wall			
Sion Vittend death. xtor:	atic	2 Accident Investigation Sep 18, 2010 13	11 hrs		es 2 V No						
Divis	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family		, factory, office bu	illding, etc.	or Town, S		Rural Route Number, City			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide Services Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, d		ed at the time, dat	e and place, a			ated.			
o the ithin 2 o the	Medical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	r investigatio	on, in my opinion,	death occurred	d at the time, date a	and place, and due to	the cause(s)			
HSHS	ž	29b. Signature and title of certifier		29c. License			29d. Date signed (A				
		シーベレー		O.C.N	n.∟.		September 19,	2010			
R21		 Name and address of person who completed cause of death (Item 23a Donna M. Vincenti, MD Assistant Medical Examine 		Penn Street,	Baltimore,	MD 21201					
	ate										
Regist	rar	SEPZZZUIU CENNY P. Mace									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frederick Guion Randall 12:55 рм 2010 September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 4807 Harvard Road College Park 8. Date of Birth (Month, Day, Year 19, 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours 92 134-12-4851 Director verpool, NY Usual Residence of Decedent fshow at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Prince George's College Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4807 Harvard Road 20740 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural" WWII White 3 X Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing n and Mental Hygier 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick H. Randall Annie Sara Hadden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shument of Health a tant: If item 27 is Penny J. Randall / Daughter 2006 Dakota Place, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 M Burial 2 Cremation 3 Removal from State Pleasant Grove Baptist 9/25/2010 Avera, Georgia 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAM Kagers Gasch's Funeral Home, PA Hyattsville, MD 20781 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1 shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiovascular Event Medical Due to (or as a consequence of) Examiner Respiratory Arrest Sequentially list conditions, it any leaves to the Cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that the death certificate be executed Metastatic Prostate Cancer and -tran that initiated events resulting in death) Last Due to (or as a consequence of). burial-1 physician s the burial Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month 4 Pregnant a Dav Year Pregnant at time of death Yes 2 No 9 Unknown P.O. I cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Reactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Frederick David Min, 2101 Medical Park Drive, #200, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) SEP 2 2 2010

3 🗌 29b. Signature and itle of certifie

(Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

D68686

29d. Date signed (Month, Day, Year)

9/20/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#8perFH, 9/21/10, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Raminer - Cruz Manue Sentembe 1430 200 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Season's Hospice Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth g. Birthplace (State or Foreign o. Date of Birth Month, Day, Xea 1980 1 X M 2 - F 30 Days Months Hours none Guatemala Director Usual Residence of Deceden 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shour or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Pikesville 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country?
Guatemala 10f. Zip Code 21208 505 Funeral Shamrock 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, et þ 1 № Never Married 2 ☐ Married Guatemalan Specify: Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 X Yes 2 No Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last)

Manuel Ramirez 18. Mother's Name (First, Middle, Maiden Surname)
Clara Luz Cruz ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2311 Cornaga Avenue Far Rockaway, New
116 19a. Informant's Name/Relationship (Type, Print) Manuel Ramirez/Father York permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of TpaTa, Chiquittula, Guatemala 9/29#2010 1 Burial 2 Cremation 3 Removal from State Municipal Cemetery 4 Donation 5 Dother (Specify) PHYLIPAD NINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 100v Medical resulting in death) Due to (or as a consequence of): Examiner Pavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown should Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 🗆 No 2 🔼 No 1 Yes Yes funeral director, 25. Was case referred to medical Serson's Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ HO Dec 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Natural
Accident
Suici 5 Pending work 1 Tes 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifle (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Dav. Year) 12 037577 Sentember 19,2010 ise of death (Item 23a) (Type, Print 30. Name and address of person who comp 2835 MD 21209 MD 31. Date filed (Month, Day, Year, 32 Registrar's Signatu State

Registrar

21

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

riin Remero-Ra	ine	1- For State Registrar		ate of Maryl		artment of rtificate of		i Mentai i		201 Reg. No.	0 31352
Physicia Medical Exami		1. Decedent's Name		_{e,Last)} o Ramirez				-	2. Date of De	ath Day Year	3. Time of Death
inculcal Exami		4a. Facility Name (if			umber)	4	b. City, Town, or I	Location of Dea		er 16, 2010 4c. County of E	
1		Washington	Adventis	Hospital	_		Takoma Par	k		Prince Ge	orge's
Funeral Director		5. Social Security N	umber	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		n.		oreign
Bilector		None Usual Residence of	Decedent	1XM 2F	17	Yrs.			02/2	0/1993	Country) Hondura
'any			10b. County		10c. City,	Town or Location	n				10d. Inside City Limits
Maryland 28a-f show any <u>d at once</u> .	for	Va	Fair	fax	Fa	lls Chu					1 X Yes 2 No
e Mary or 28a	Director	10e. Street and Nun 7521 Lee					10f. Zip Code 22042			10g. Citizen of What Hondura	•
6, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	la [11. Marital Status	- 11117	12. Was Dec	cedent Ever in U.	S. 13. Was	Decedent of Hisp	panic Origin? (§	Specify Yes or N		merican Indian, Black,
death	Funeral	1 X Never Marrie		arried Armed F	2 🗶 No	If Ye	s, specify Cuban,			White, e	tc.
rs after ural", miner	by	3 Widowed		orced If Yes, Give Yes or Dates: cify only highest gra-			Yes 2 No s Usual Occupati		ndurian	Specify: 1	Hispanic
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21215-0036 should be filed within 7 and Mental Hygiene, is marked other than atte event, the Medical	Be Co	17. Father's Name (In Daniel R		Last)			1		e (First, Middle, Lili Rar	Maiden Surname) Nirez	
212 ould be d Ment s mark	To E	19a. Informant's Nar				19b. Mailing	Address (Street	And the Later Control	LOUIS - 100 P	mber, City or Town, S	State, Zip Code)
MD and 2 show alth and m 27 is		Doris lil		rez/Mothe			_			Va 22042	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 X Burial 2		3 Removal fr	om State	rematory or other			Date	20c. Location - Cit	,
iltim nit. Pagartment artment ortant		4 Donation 5 21. Signature of Fun					Cemetery		26/10	Hondui	
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Examiner	1	Immediate Cause (For condition resulting		a. Multiple Gu	consequence of						Death
		Sequentially list con	ditions,	b		,. 					
	ine	if any, leading to imr cause. Enter Under	lying Cause	Due to (or as a	consequence of):					
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certificate be exect anding physician an order as the burial - true	Med	IF FEMALE:		23c. If yes,	outcome of pregn	nancy			-	23d. Date of deli	very
certifica	ian/	23b. Was decedent p past 12 months?		e 1 Live b		2 Feta	I death 3	Ectopic pregn	ancy	Month	Day Year
O. Box 6876 that the death certifican red by the attending phy detached for use as the	Physician/Medical	1 Yes 2 No	9 Unk	nown 9 Unkno		5 Othe	(Specify)				
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	ted	-							24a. Was		a autopsy findings available
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		25. Was case referre	ed to medical	9			26.Place o	of Death (Check	1 Yes	2 No 1 ✓	Yes 2 No
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⊂ ਚੋਂ ੂੈ ਵੀ		27. Manner of Death 1 Natural	5 Pend	28a. Date Sep 16,	of Injury Day Year) 2010	28b. Time of Inju 1851 hrs		at Work? s 2 ✔ No	28d. Describe Subject sho	how injury occurred	
Division tal or Attendia rs after death. al Director: A	icati	2 Accident	Inves	tigation 28e Place	e of Injury - At ho				28f. Location (Street and Number or	Rural Route Number, City
Division of Prints or Attending Phours after death. Beral Director: After tilled in by the funeral	Certification:	3 Suicide 4 ✔ Homicide		not be	Park/Recrea				or Town, S		
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical (se(s) and manner as s and place, and due to	
	Mec	29b. Signature and ti		and manner st	ated.	-	29c. License		·	29d. Date signed (
2		All	a	-	MA		O.C.M	.E.		September 17	, 2010
		30. Name and addres			e of death (Item 2 edical Exami		enn Street, E	Paltimoro M	D 21201	•	-
Sta	ite	31. Date filed (Month)	Dav. Year)	32. Re				ailiniore, M	D 2 120 1	<u> </u>	
Regist		SEP	21 20 1	U Seneu	U B. 1	que					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ September 17 Nettie <u>Virginia Russ</u> 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 301 Kingswood Terrace
al Security Number 6. Sex Washington <u> Hagerstown</u> 8. Date of Birth (Month, Day, March 20, 9. Birthplace (State or Foreign Country) MaryLand 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 M 2 X F Director 81 220-30-8870 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Washington Hagerstown MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21742 301 Kingswood Terrace USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 N Widowed 4 Divorced Black Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) t.h Homemaker Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Allen Burnett Elizabeth Marie French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kingswood Terrace, Hagerstown, MD 21742 Lesley A. Smith / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State ö 109/25/2010 |Smithsburg, MD 4 Donation 5 Other (Specify) Smithsburg Crematorium any injury Signature of Fuperal Service License 22. Name and Address of Facility Gerald N. Minnich Funeral Home By-KT 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 has autopsy performe this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ₽ 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 1126 cpal Ct. Hagerstown, MD 21740 31. Date filed (A Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 1 0

Jeffrey Fr	ritzgeral	1	- For State	State of Maryla	and / Dep <i>Ce</i>	artment of ertificate of	f Health and f <i>Death</i>	Mental		Z U 1 I Reg. No.	1 31334
-	hysicia		Registrar 1. Decedent's Name (First, I	/liddle,Last)					2. Date of De	ath	3. Time of Death
Madical		ner	JEFFREY		GERALD	RUSI				er 17, 2010	1440 hrs
			4a. Facility Name (if not inst		umber)		4b. City, Town, or L	ocation of De	ath	4c. County of Dea	
			Prince George's H			Land Cab day	Cheverly	List Index 2.4	Um 10 Data of F	Birth (MM/DD/YYYY) 9. I	
	uneral irector		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year Months Days	If Under 24		For	eignNEW JERSEY
D	rector		135-66-1667	1XM 2 F	46	Yrs			NOV.	20 1703	Country)
	any		Usual Residence of Decede 10a. State 10b. Cor		10c. Cit	ty, Town or Locat	ion				10d. Inside City Limits
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uvlan	Sa-f s	왕	MD PRI 10e. Street and Number	NCE GEORGE!	S	AUREL	10f. Zip Code			10g. Citizen of What Co	ountry?
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with	ns 23;	uneral	11. Marital Status	12. Was De	cedent Ever in	U.S. 13. Wa	as Decedent of Hisp es, specify Cuban,	anic Origin?	(Specify Yes or N	lo- 14. Race - Am White, etc	erican Indian, Black,
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after	ral", c	by F	3 Widowed 4	Divorced If Yes, Give Ye or Dates:		1	Yes 2X No		of work done	Specify: BL	
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36 in 72	than dical	ompleted	Elementary/Secondary (C	5+	1 (0.01)	PHARM	ACEUTIAL	INSTRU	CTOR	PRIVATE	
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MD 21215-0036 3 should be filed within 72 hours after death with the Maryland	Departit. 1988: 1 and 2 should be little William 2 hours are beauf with the many taken Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Rela							umber, City or Town, St	
M Z	on 27		SHELIA JOHNS 20a. Method of Disposition	ON/SISTER	Look		BERGEN AV sition (Name of cem		Date Date	TY, NEW JE	
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Baltimore,	rag ment tant: or ot		4 Donation 5 Oth		E	BAYVIEW	CEMETERY Name and Address			JERSEY CI ENKINS FUNE	
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/IV	ledical.		failure. List only one of	Adultin la la	iuries						Between Onset and Death
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		ine	if any, leading to immediate cause. Enter Underlying C	ause	a consequence	e or):					
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Box	the a	hys	1 Yes 2 No 9 Part II. Other significant c			et resulting in the	underlying cause d	iven in Part I	23e Did	tobacco use contribute	to the cause of death?
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喜	ysıcıan: his certi director	Be	25. Was case referred to m examiner?	Hospital:	Inpatient 2	✓ ER/Outpatien		O#		Residence 6 0	her:
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o Lo	uth.	tion		rending .	th, Day Year) , 2010	1400 hrs	1 □ Y	es 2 🗸 No	Motorcyck	e driver collided	with car
Division	or Attenather death Director:	fica	2 🗹 Accident 3 Suicide 6	Investigation 28e, Pla	ice of Injury - A	t home, farm, stre	eet, factory, office b	uilding, etc.	or Town	State	Rural Route Number, City
يَّ جَ	ospital or Attend hours after death ineral Director: y filled in by the	Certification:	4 Homicide	determined (Specif)	<u> </u>	oad / Highwa			9600 Ft. Me	eade Road, Laurel, M	
	I of the Hospital or Attending Fin within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		(Ontook only	ing Physician: To the be	est of my knowl	ledge, death occu	urred at the time, da	ite and place,	and due to the ca	use(s) and manner as s	stated. o the cause(s)
	vithin 2 To the complet	Medical		and manner	stated.	and/or investiga	29c. License		od at the time, ua	29d. Date signed (
		Σ	29b. Signature and title of o	xertiller	0		O.C.I			September 18	
			Mangarie	Vme Incl	l	10m 02=1	0.0.1			1	30 0
K 1	0		30. Name and address of p Margarita Korell N				Penn Street, Ba	altimore, M	1D 21201		
		tate	31. Date filed (Month, Day,	Year) 32. I	Registrar's Sign						
	Regis		SEP 2 1 20	10 Senera	B. A	Jarke					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) NOBLE 2. Date of Death 3. Time of Death RIDINGS, JR. В. Physician/ 24, Day 2010 Year SEPT. 8:36 Ам Medical 4a. Facility Name (if not institution, give street and number)
GOLDEN LIVING CENTER Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WV 232-46-3799 1 □XM 2 □ F 82 16971071927 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location MARTINSBURG 10b. Coun 10d. Inside City Limits Director BERKELEY WV 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25401 1002 NASH COURT Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes Completed by Baltimore, Maryland 21215-0036 within 72 hours after WHITE 1 Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify 3 XXWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) E.I. DuPONT College (1-4 or 5+) MAINTENANCE Be 17. Father's Name (First, Middle Last) NOBLE B. RIDINGS, SR. 18. Mother's Name (First, Middle, Maiden Surname) MABLE PAULINE THOMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 NASH CT., MARTINSBURG, WV 25401. 19a. Informant's Name/Relationship (Type, Print) GLENDA NORRIS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of SEPT 28 20c. Location - City or Town, State cemetery, crematory or other place) ROSEDALE CEMETERY 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 MARTINSBURG, WV 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821. MARTINSBURG, WV 25402 327 W. KING ST.. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MITER Physician/ ATHERO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EMENTIA XERMS S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.

To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending work' M 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9-30-2010 ame and address of person who completed cause of death (Item 23a) (Type, Print) REDERICK Mn DIBTE A. KAZMI, HID 814 TOLL HOUSE AUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

OHMH 17 Rev 7/2009

DK

Registrar

ORIGINAL

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For AMEND#26 per I State Registrar 9/20/10 AA	LIL	-	-	tificate c			u Went		eg. No.	2010		313	356
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Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. i	ast birthday) Yrs.	If Under 1 Y		If Under 24 H		te of Birth onth, Day, e 12,		g Bi	untry	ce (State or	-
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant 9 Unknown	at time of		Other (specif						Month	Da	ay Ye	ear
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withi		29b. Signature and title of certified)	A	2 1	29c. Lic	cense r	number	ų	2	gd. Date:	signed (Mon	th, Day	, Year)	
		30. Name and address of person	who completed assess	death (to	23a) (Tima B	rint)	DI	182			Septe	ember	- 41	0,25	010
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Stat Registra		31. Date filed (Month, Day, Year) SEP 2 (2010 32. Regist	rar's Signa	ture.	all	\$								

SMITH, DANITRA

			Please	Type or Prin							egible.	
		•	For State Registrar	State of Ma	ar ylai lu /		cate of L		wientanny	Reg. No. 2	010	31357
	Physicia Medic		1. Decedent's Name (First, Middle, Lass Danitra S. Smi	,					2. Date of De Month	eath NBER 1	5 2016	3. Time of Death 4:26 AM
~ ~	Examin	er	4a. Facility Name (if not institution, give BALT, mode WASHL 5. Social Security Number 6. Se	OCTON MED	ICAL C	ENTER birthday) If 1	Jnder 1 Year	LEN Deat	h ひRいE 」8. Date of Bi	4c. Cou	unty of Deatl	ARUNDEL hplace (State or Foreign
ek.	Director		213-80-9397 ¹ Usual Residence of Decedent	□м 2 Х] F	41	Yrs. Moi	nths Days	Hours Min.	Mar ^{th,} 1	8 ^{Yea} 196		ryland
	nyland t-f show ied at	Director	10a. State 10b. County Maryland Anne A	rundol	•	own or Location	1					10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	ith the Ma 23a or 28a st be notif		10e. Street and Number 8124 Mountain				of. Zip Code 2112	2		10g. Citizen	of What Co	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by F	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ I If Yes, Give Year or Dates.	ver in U.S.			ispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 14.	Race - Amer Black, White	
Maryland 21215-0036	vithin 72 hour jiene. er than "natu the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12) 12th			life. DO NO	of work done of Tuse retired)	during most of wo		Ī	of Business	Maryland
land 2	i be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Leslie R. Broa	,	'			18. Mother's Na	me (First, Middle A. Don	, Maiden Surn		
, Mary	nd 2 should ealth and N m 27 is ma ier traumai		19a. Informant's Name/Relationship (7) Kelvin E. Smit		oand)	8124	Mount	and Number or Ri				o _{Code)} 21122 ena, Md.
Baltimore,	. Page 1 al tment of H tant: If itel jury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		20b.Hidce ceme Mem	dofDisp@sklee etery, cremator orial	Garde	ns 9-2	Date 22-10	Anna	-	s, Md.
Ball	21. Signature of Funeral Service Licensee Winame Receive of Facility Sons Mortuary, P 821 West St. Annapolis, Md.											
	nysician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition			oo not enter the					ni	Approximate Interval Between Onset and Death
7.	Medical Examiner		resulting in death) Ecquentially list conditions,	Due to (or as a	consequence	ce of):	CAN	DIAL DIAL	MA	yMa	in	
0	s be executed sician and burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	CH	HOIO	MOP	An 4				
. Box 68760	ie de th certificate be r the attending physicial ched or use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 1 4 Pregnant at 9 Unknown	2 🔲 Fetal de	eath 3 🔲 Ect	opic pregnander (specify)	су		23d	. Date of del Month	ivery Day Year
ls, P.O	requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death be	ut not resultir	ng in the underl	ying cause gi	ven in Part I.				the cause of death?
Division of Vital Records, P.O.	The law ate has page 2	Completed									4b. Were aut prior to death?	topsy findings available completion of cause of
/ital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ant 2 TER	Outpatient 3	Oth	er:	eck only one) Home 5 \square Res	idence 6 🗆	Other (Spec	ifs/)
n of	nding Phys th. : After this e funeral di		27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident Investigation	28a. Date of injur (Month, Day	y 281	b. Time of injury	28c. Injur work	y at	28d. Describe			
Divisio	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director, After this completed filled in by the funeral	I Certificate:	3 Suicide 6 Could not b 4 Homicide determined			, farm, street, fa	actory, office			(Street and Nu wn, State)	imber or Rui	ral Route Number,
	the Hospi in 24 hou the Funer ipleted fill	Medical	(Check 2 Medical Exami	sician: To the best of oner: On the basis of exise Practioner: To the l	camination an	nd/or investigation	n, in my opini	on, death occurred	at the time, date	and place, and	d due to the o	cause(s) and manner stated.
_	To t With To t		29b. Signature and title of certifier	silu			29c. Licens	e number	103	29d. Date si	-	
	4		30. Name and address of person who of BACIMONE	completed cause of de	eath (Item 23.	a) (Type, Print)	Tsic	on Berh	ane	SUN	Bus	NO MS.
	Sta Registra		31. Date filed SEP 2 0 2010		r's Signature	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 31358 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elaine Smith Physician/ Doris 'nb 11:210 M Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Nicomico lis d If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last 8. Date of Birth Funeral 1 □ M 2 🗶 F Months Hours 0472771928 Maryland 218-24-4495 Director 82 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Salisbury Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n by Funeral 21804 USA 1110 Healthway Dr., Apt. 231 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Import. It; If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: white Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry P ge 1 and 2 should be filed within 72 P m nt of Health and Mental Hygiene. Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) domestic housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Viola Pritchett Harry Karcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20l Courtland Dill Rd., Harrington, DE 19952 James B. Dunn/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/22/2010 Greensboro, MD 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery ture of the rice Licensee Thomay Tufferal Home Professional Association Rompson 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ ISCHEMIC BOWZL Medical resulting in death) Due to (or as a consequence of): Examiner CORONARY DISRASR Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) signed by the at a be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy perform Yes Yes 2 No this certificate Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2×100 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 Natural 5 Pending 2 🗆 No Accident Investigation after death completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 8410 'th 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month sarene Physician/ OD PM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Capital Heights 1527 Ruston Ave If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 **X**F SC 228-22-4059 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at Director Prince George's Capital Heights 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 20743 "natural", or items 23a 1527 Ruston Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Black 1 ☐ Yes 2 😾 No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Operator Government $7_{\pm h}$ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked o permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Gilbert C. McCoy Anna Ginyard o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
527 Ruston Ave.
apital Heights, MD 20743 19a. Informant's Name/Relationship (Type, Print) Desarene Arnett-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Lincoln Ceme 1 X Burial 2 Cremation 3 Removal from State Ft. 9/25/2010 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility DL McLaughlin Funeral Home 2019 MLK Jr Ave SE, Washington DC 20020 Signature Funeral Service Licensee Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₹hysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a conseq resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 performed' 1 ☐ Yes 2 ☐ No Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Hospital: 2 X No. ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work? 1 Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar
DHMH 17 Rev 7/2009

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMFND#5perTNF, 9/28/10, EMW, McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:33 a September 19, 2010 Garbis Sarkis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Sept. 26, 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number 119674675920 **Funeral** ^{Year} 1949 Days Hours Min. Syria 1 X M 2 □ F 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at 1 ☐Yes 2 No Director P.G. Beltsville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20705 11023 Cherry Hill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 3 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>Ş</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event and once." College (1-4or 5+) Elementary/Secondary (0-12) Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Lucie Ekmekjian Krikor Sarkissian ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11023 Cherry Hill Road, Beltsville, MD 20705 Annie Sarkis/Wife Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 23 Sept. 2010 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYO CARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □ Yes 2 No P.0. ed by the detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 17No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 27. Manner of Death 1 ☑ Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 (Progratifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Within 2. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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D40324

SEPTEMBER 20,2010

TAKOMA PARK, MARYLAND 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Raymond Sinopoli September 20, 2010 Clifford 3:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockv111e 17704 Caddy Drive Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Yea 1 🕅 M 2 🗆 F 90 Months Days Hours Min 156-09-7344 1920 New York Director Usual Residence of Decedent 28a-f show 10h County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17704 Caddy Drive 20855 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married X Yes 2 No World hours after ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates. War Completed TT White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Elementary/Seconday (0-12) College (1-4 or 5+) Chemist Government Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gabriel Leonard Sinopoli Sarah Frances Truebig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Sarah E. Stokely (Daughter) 4151 Bill Moxley Road, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o Quantity Comminat Therelate Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery Triangle, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home. M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1 the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock the heart failure. List only one cause on each line.

Immediate Cause (Final Cardiac Arrest Approximate nterval Between Onset and Death Physician/ Cardiac Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Artery Disease years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): s the burial-transit Examir The law requires that the death certificate be executed Hypertension years that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Diabetes Physician/Medical years for use as IE FEMALE f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hydrocephalus 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of page certificate 1 Yes 2 No Il or Attending Physician: after death.

Director: After this certifications 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 XNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D60401 September 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veronica Ann DiFresco, M.D., 1201 Seven Locks Road, Suite 111, Potomac, MD 20854 2. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician SHROY 8:53 AM 09 CATHERIN 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ALLEGAN LIVING CENTER CUMBERLAND GOLDEN If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 🖼 F Months Days Hours 211-05-2374 9 mo Director 2-6-1918 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medicin Evanting must be notified at ALLEGAN MO CUMBERLAND 1)Yes 2□No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Winitred 21502 512 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc should be filed within 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 2 Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important; if item 27 is marked other than "na any injury or other traumatic event than "na once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL CLOTHING CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHAFFER GLADYS CHRISTINA SSELL EARL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McMullen Hwy Cumberland MD Z150Z Linda altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ■ Removal from State 9-17-2010 HYNDMAN PA HUNDMAN CEM, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HARVEY H. ZEIGLER FUNERAL HOME INC 169 CLARENCE ST HYNDMAN PA 15545 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 0 ohi disease or condition resulting in death) /Medical Due to (or as a conse wence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and law requires that the death certificate be exect Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≥</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 No page 2 1 □ Yes 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending re Funeral Director: Af blotely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 the 29b. Signature and title of ee 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person tho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

SEP 16 2010

D0033280

625 KENT AVE SUITE 101 Comberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland / Department of Health and Me Certificate of Death	ental Hygien Reg. N	2010	31363				
Physicia Medic		Shirley R. Schurg	2. Date of Death Month September	Day 13, 2010	3. Time of Death 01:37 AMM				
Examir			4	c. County of Death					
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F Real Factority Number 218-30-0131 7. Age (In yrs. last birthday) 1 F Worth Real Factority Number Nonths Days Hours Min.	Date of Birth (Month, Day, Year) November 2	9. Birth County	place (State or Foreign lary)and				
/land f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
the Mar a or 28a- be notifie	Funeral Director	Maryland Allegany Frostburg 10e. Street and Number 12420 Vale Summit Road 10f. Zip Code	_	Citizen of What Cou	1 Yes 2 □ No				
death with items 23		21532- 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Fyes, specify Cuban, Mexican, Puerto Rican, Puerto	y Yes or No-	J.S.A.					
ZI 3-UU36 iin 72 hours after e. han "natural", or Medical Examir	ted by	1 □ Never Married 2 Married 1 □ Yes 2 No		Black, White,	hite				
TZIS-	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress		Kind of Business In	dustry				
partimore, Maryland Z1Z13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show ampringing or other traumatic event, the Medical Examiner must be notified at ance.	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fi							
Maryland 2 should be filed th and Mental Hy 27 is marked off traumatic event		19a. Informant's Name/Relationship (Type, Print) Carl F. Schurg Husband 19b. Mailing Address (Street and Number or Rural Ro 12420 Vale Summit Road Fros	or Town, State, Zip Maryland						
Jore, I		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	e 20c.	Location - City or T					
Daltimor permit. Page 1 Department of Important: If it any injury or o	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 F							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re shock, or heart failure. List only one cause on each line.		iostotilg, ML	Approximate Interval Between				
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			Onset and Death				
Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	-						
r ov cate be executed physician and s the burial-transit	Examiner	Cause (Disease or initigity that initiated events resulting in death) Last C. Due to (or as a consequence of):	Due to (or as a consequence of):						
ificate be g physici as the bu	Medical	d							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliv Month	ery Day Year				
puires that the signed by uld be detail	by	Part ii. Other significant conditions continuoung to death but not resulting in the underlying cause given in Part i.	use contribute to t	8 4					
The law requires rate has been signage 2 should b	Completed		24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of 2 No				
vital nysician: nis certific I director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	, ,	6 ☐ Other (Specif	()				
r Attending Pl r Attending Pl fter death. irector: After th n by the funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Yes 2 No	d. Describe how inju	ury occurred					
tal or Att Irs after de al Directe led in by t			f. Location (Street a City or Town, Stat	nd Number or Rura e)	l Route Number,				
the Hospi nin 24 hou the Funer	Medical		e time, date and plac	e, and due to the ca	use(s) and manner stated.				
N with		29b. Signature and title of certifier 29c. License number 29c. License number		ate signed (Month,	Day, Year)				
MM		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALIT Sidhu 935 Bishop WAISH Rd Cumberly	•	1D 21					
Stat Registra		SEP 16 2010 Server 32. Registrar's Signature 32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		State of M	aryiand	Cer	tificate of l	Death	nentai Hy	Reg. No		31364		
Physicia Medic		1. Decedent's Nam		st) Henr	У		Schellha	ius	2. Date of De Month Septe	D	ay 24, Year 20	3. Time of Death 10 4:17 P M		
Examin			f not institution, give	e street and number)	Y	-		r Location of Death			4c. County of Death Allegany			
Funeral Director		5. Social Security N 217-28-88	6. S 312	Sex 7. Ag	e (In yrs. last 78	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10 / 16	ay, Year)	Co	thplace (State or Foreign untry) aryland		
aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Allegany Cumberland					nd	10d. Inside City Limits 1 □ Yes 2 ☑ No						
with the M 23a or 28 ust be not	Funeral Director	10e. Street and Nur					10f. Zip Code	502		10g. C	0g. Citizen of What Country?			
after death I", or items xaminer m	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2 Married	12. Was Decedent I Armed Forces? 1 V Yes 2 If Yes, Give	№ 195	1	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - Ame Black, Whit	e, etc.		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	-	15. Decedent's E ecify only highest gr		5+)	16a. Deced (Give l life. D	O NOT use retired)	during most of worki			Kind of Business			
e filed with ntal Hygien ed other ti e vent, th e	To Be Co	12 17. Father's Name (Robert		Francis		<u>Distr</u> hellh		Coordinat 18. Mother's Name Alice			ire and Sumame) Mullan			
12 should bath and Me 27 is mark r traumatic	•	19a. Informant's Na	ame/Relationship (7 Schellhau	ype, Print)		19b. Mailin	g Address (Street	and Number or Rura brook Roa	al Route Numbered, Cum	er, City o berl	r Town, State, Zi	o Code)		
Page 1 and ment of Hes ant: If item ury or othe		1) Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1) Burlal 2 Cremation 3 Removal from State St. Patrick's Cem 09/27/2010 Mt.								it. Sava	on - City or Town, State Savage, MD			
permit. Departi Import any inj		21. Signature of Fur	neral Service Licen	daros				ss of Facility Actur Street				1 Home, P.A. 21502		
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as consequence of): Due to (or as consequence of):												
Examiner	ner	Sequentially list conditions, fi any, leading to immediate Due to (or as a consequence of):												
sate be executed physician and the burial-transit	cal Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	iinjury s	C. Due to (or as	ce of):									
5 5	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal de	eath 3 🗌	Ectopic pregnand Other (specify)	су			23d. Date of de Month	livery Day Year		
uires that th signed by lid be detac	þ	Part II. Other signif	icant conditions o	ontributing to death b	ut not resultii	ng in the u	nderlying cause giv	ven in Part I.				the cause of death?		
The law requate has been bage 2 shou	Completed								24a. Was auto perfo	psy ormed?	prior to death?	topsy findings available completion of cause of		
sician:	To Be (25. Was case referre examiner? 1 Yes 2		Hospital:	ent 2□ER	Outpation	Oth	ace of Death (Checker:	only one)					
ending Phy eath. or: After this he funeral c	Certificate: T	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending Investigation	28a. Date of inju (Month, Day	ry 28	b. Time of injury	28c. Injur work	y at		X Residence 6 ☐ Other (Specify) cribe how injury occurred				
oital or Att		3	6 ☐ Could not be determined	28e. Place of Inju building, etc	c. (Specify)				City or Tov	vn, State	•)	ral Route Number,		
o the Hosp ithin 24 ho o the Fune ompleted f	Medical	(Check 2	☐ Medical Exam ☐ Certifying Nur	sician: To the best of iner: On the basis of e se Practioner: To the	xamination an	d/or invest	gation, in my opinio	on, death occurred at e time, date and plac	the time, date a	and place ne cause(e, and due to the	cause(s) and manner stated. stated.		
63		1	Mou	completed cause of d) (Time P	D22	2181			_	27, 2010		
×		Gary	L. Wagor	ner, M.D.,	925	Bisho	op Walsh	Road, Cur	mberlan	d, M	1D 2150	2		
Stat Registra		31. Date filed (Montl		2010 32. Registra	ar's Signature		arked							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Stover 2010 Albertus September 5:58 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 19218 Woodhaven Drive Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Months Davs Hours (Month, Day, Year) Director 30 1917 166-01-1443 Pennsylvania Usual Residence of Decedent 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location with the Maryland at Director or 28a-f s notified 1 Yes 2 No Maryland Washington Hagerstown ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 19218 Woodhaven Dr. 21742 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Engineer <u> Aircraft Manufacturing</u> other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Roy W. Stover Mary Μ. Gilland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cloria Clem / Niece 18421 Wagaman Rd. Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/24/2010 Hagerstown Maryland Haven Cemetery 21. Signate of Fuller Strvice Ly 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MO disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a conse, uence of -transit Cause (Disease or iinjury that initiated events resulting in death) Last executed Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ned by the atten edetached for u in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be o 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? Yes 2 N 1 🗌 Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or within 24 hours after death.

To the Funeral Director: After this c မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗆 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, MI 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

gistrar's Signature

			Plea	ase Type or							-		•	e.	
			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1								0010	31361	5		
	- · · ·		Decedent's Name (First, Middle	e, Last)							2. Date of De	eath		3. Time of Death	s S
	Physicia Medi				сох						Septem Septem	ber	12 2010	13:37	М
	Examir	ner	4a. Facility Name (if not institution		nber)		4b. City, 1			of Death		4	c. County of De		
-	Funeral		9780 Howes Roa 5. Social Security Number	ad 6. Sex	7. Age (In yrs. Ia	ast birthday)	Du If Under	nkiı 1 Year	k If Under	24 Hrs.	8. Date of Bi	rth_		vert Firthplace (State or Foreig	nn.
	Director		170-42-6332 Usual Residence of Decedent	1 X M 2 □ F	61	Yrs.	Months	Days	Hours	Min.	04-09-	194°	9	inthplace (State or Foreig Country) PA	
	show dat	호	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limit	s
	Mary 28a-1 otifie	ire	MD Calve	ert				nkiı	ck					1 ☐ Yes 2 🔀 N	10
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at the Medical Examiner	Funeral Director	10e. Street and Number				10f. Zip					10g. C	Citizen of What C	Country?	
	ath w	nue	9780 Howes Roa		dent Ever in U.S	13.1		754	spanic Orl	gin? (Sne	cify Yes or No-	-	USA 14. Race - Am	poricen Indian	_
9	er de or ite	by F	1 Never Married 2 🕅 Mari	Armed Fo	rces?] '	f Yes, speci	fy Cuba	n, Mexicar	n, Puerto I	Rican, etc.)		Black, Wh		
003	ursaf .ural", al Exa	ted	3 Widowed 4 Divorced	Year or Da	e ates.1968-	72	I ☐ Yes 2	2 LX No	Specify:				Specify:	vhite	
15-	72 ho "nat ledica	Completed		nt's Education est grade completed)	17	(Give	dent's Usual kind of work O NOT use :	k done d	ation <i>luring m</i> os	t of worki	ng	1	Kind of Busines	•	
21215-0036	vithin liene.	ပြီ	Elementary/Seconday (0-12)	College (1	-4 or 5+)		Serv	,	s Tec	hnici	ian		tail Loss Preventior ecurity Systems		
	filed value of other of other of other svent,	Be	17. Father's Name (First, Middle, L	_ast)	-						(First, Middle			Dybeemb	_
Maryland	d be Ment arke	₽	Robert Key	Silcox						trici			Mille		
Mar	shoul h and 7 is m trauma		19a. Informant's Name/Relationsh	, , , , ,		1							or Town, State, 2	Zip Code)	
	and healt		Elizabeth J. S	ollcox, sp		lace of Dispo			ad,		irk, MD Date		0754 Location - City o	or Town State	_
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State C	emetery, crer • John	natory or oti	her plac					-	ederick, MD	
altii	permit. P Departm Importal any injur		21. Signature of Funeral Service L		50								1 Home,		_
<u>m</u>	<u>a a E e a</u>		William	- R. Gr	0-								s, MD 20		
4.	ath certificate be executed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	dical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	b. Due to	or as a consequence or a con	ence of):					-UNI		e W N KI	Approximate Interval Between Onset and Death 3 M GN-11/LS	
D. Box 68760	the de by the ached	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live 4 Preg 9 Unkr		I death 3 Leath 5 L	Other (spe	ecify)					23d. Date of d Month	elivery Day Year	
, P.O.	es that igned b		Part II. Other significant condition			ulting in the u	nderlying ca	ause giv	en in Part	I.				to the cause of death?	
rds	require been sig should k	eted	HYPER	IENSIE	10									Probably 4 Unknow	_
Reco	The law roate has b	Completed by	1+41ER	LIP 10 E.	MIA-						24a. Was auto perfo 1 Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of second 2 No)
tal	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Pla	ace of Dear		only one)	71	_		_
of V	Phys r this or	3: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date	Inpatient 2 of injury	ER/Outpatier 28b. Time of		A Cirie	4 ∐ N∟		me 5 K Resi		6 Other (Spe	ecify)	_
on C	nding ath. r: Afte e fune	icat	1 Natural 5 ☐ Pendin 2 ☐ Accident Investig	ig (Mont	h, Day, Year)	injury	M	work'	? Yes 2□		od. Describe i	now mja	ny cocumed		
Division of Vital Records,	al or Atte s after de I Directo d in by th	Certificate:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place	of Injury - At hong, etc. (Specify)		eet, factory, office 28f. Location (Street City or Town, Str					ural Route Number,			
	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director. After th completed filled in by the funeral	Medical	(Check 2 L Medical E	Physician: To the bas xaminer: On the bas Nurse Practioner:	is of examination	and/or invest	igation, in m	ny opinio	n, death oc	ccurred at	the time, date a	and plac	e, and due to the	e cause(s) and manner sta	ited.
	To the within to the Confidence of the Confidenc		29b. Signature and title of certifier	1/1		,	29c.	License	number			29d. Da	ate signed (Mon	th, Day, Year)	
			Menty	Hulean	reagh	MO		1-0	020	090	2	Sej	ptember	13, 2010	
dr	w 15+1		30. Name and address of person v Stanley Wisnie					ntin	ıgtowı	n, MI	20639				
	Star Registra		31. Date filed (Month, Day, Year)		Signate Signate		par	Kal							_

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 02:49 PM Sept<u>ember</u> James Peter Seen Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min New York 3/18/1939 Director 061-32-0907 71 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🌠 No Marvland Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 790 Eastern Point Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 M Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Construction year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jessie Elizabeth Rose Peter Abraham Seen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 790 Eastern Point Rd., Annapolis, MD 21401 Margaret M. Seen/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Lakemont Cemetery 9/18/10 4 Donation 5 Other (Specify) Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocar ala disease or condition Medical resulting in death) Examiner Memic Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown I Director: After this certificate has been signed by din by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 09-16-2010

State Registrar 122

MID

Defense themay Sufe 200 Annapolis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIA E. ROMERO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 24 Hrs. Hours Min. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Days (Month, Day, Yea 215-70-8216 51 Marvland Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Prince George's Landover 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 7723 Burnside Road 20785 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 X Never Married 2 Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: **Black** 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. em 27 is marked other tha item 27 is marked other that other traumatic event, the I 12 years Mechanic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd William Snowden Margaret A. Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7723 Burnside Road Landover, MD 20785 Margaret A. Snowden - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o ₹ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Washington Nat'l Cemt. Sep 23, 2010 Suitland, MD ≥2. Name and Address of Facility Stewart Funeral Home, Inc. of Funeral Service 4001 Benning Road, NE Washington, DC 20019 23a. Pan 1. Inter the disease, or complications that caused shoo, heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by venous Mombosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an troke autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 XInpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Norse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R J Sta

Registrar

no completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** . Social Security Number If Under 24 Hrs 7. Age (In vrs. last birthday) 8 Date of Birth 9 Birthplace (State or Foreign Funeral (Month, Day, 1 🗆 M 2 🕱 F Months Days Hours 578-20-0948 Director 88 DC Aug. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature." 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3298 Fort Lincoln Drive NE 20018 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 A No Specify: Black Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ 12th Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ophilia Brown Casper H. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Chartsey Street Upper Marlboro, Md. Aubrey E. Smith/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1

Burial 2 □ Cremation 3 □ Removal from State 21, Suitland, Maryland Lincoln Memorial 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service Lic 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner tri Culni Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita 1 ☐ Yes 2 ☑ No Other: 옏 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOOK 31. Date filed State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0302 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL TENINSLICA REGIONAL Nicamico SALISBUR If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 1 🔀 M 2 🗆 F 62-7550 Country) **Director** 19 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ACGO MACK 1 X Yes 2 No rginia 10e. Street and Number 10g. Citizen of What Country? Funeral 5. 20431 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) NSUVANCE College (1-4 or 5+) NSUTANCE ClAIM () Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other. pe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VESA SPOUSE 15 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 24/2010 TEMPEVANCE VIIIE 15 21. Signature of Funeral Service Licensee 22. Name and Address of Facility TEMP. 23442 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple organ failure
Due to (dr as a considence of): disease or condition resulting in death) Medical Examiner Sepsis sundrome Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death signed by the a Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respiratory failure 1 Yes 2 No 3 Probably 4 Unknown End stage Obstructive Sleep Apnea 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 2 👿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Tes 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🔲 Homicide City or Town, State) Medical 29a Certifier 1 VCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D7096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year) SEP 2 7

2

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month TAYLOR MARVIN **EUGENE** PTEMBER 2010 9:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HOSPITAI TAKOMA PARK WASHINGTON ADVENTIST Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Hours JULY 26 NORTH CAROLINA 48 218-90-9376 Director Usual Residence of Decedent 23a or 28a-f shov lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No PRINCE GEORGE'S LANHAM MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9877 GOODLUCK ROAD 20706 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify: 3 Divorced "natural" Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 11THDOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROBERTA BROWN WILLIAM J. TAYLOR . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9877 GOOD LUCK ROAD #4 LANHAM, MARYLAND 20706 WILLIAM J. TAYLOR/FATHER Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 9/20/2010 RIVERDALE, MARYLAND 21. Sign at re of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADVANCED HIV/AIDS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I 2x□ No 1 Yes Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 9 2010 Carrol Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar WASHINGTON ABVENTIST HOSPIT AT

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 12:18 pM 2010 GARY EDWARD THOMPSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Western MD Regional Medical Center Cumberland **Allegany** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 **X**M 2□ F Months Min. Director 218-38-0203 08/06/1941 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** LaVale MD **Allegany** 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with thent of Health and Mental Hygiene. U.S.A. 12302 Dressman Lane, N.W. 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: ģ Specify: White 3 ☐ Widowed 4 ■ Divorced "natural" Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Service Manager Automotive 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Edward Thompson Pauline Wyoma Moats ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 9120 Downsville Pike, Williamsport, MD Michelle Thompson Jones / Dau. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Hillcrest Meml. Park 09/22/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Upchurch Funeral Home, P.A. 21. Signatur of Funeral Service Licensee 21502 202 Greene Street, Cumberland, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Immediate tause (Final disease or condition resulting in death) **Physician** econs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to manuscribate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a consequence off Examiner -tran and Due to (or as a consequence of): burialphysician s the burial Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Lakhown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes ZUNo Disbetes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 D Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ER/Outpatient 3 □ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Nanner of Death Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

8

Hospital

or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

the Maryland

Baltimore, Maryland 21215-0036

Broad Ian, 31. Date filed (Month,

2010

29b. Signature and title of pertifier

D21244

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19,2010 Physician/ 8:08 AM <u>John Alexander TURNER</u> entember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F (Month, Day, Year) 19. 8 1958 Months Maryland Director 52 220-76-2006 ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 X Yes 2 No Maryland | Washington Hagerstown 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21740 428 W. Franklin Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: I Hygiene. other than "natural", White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Photographer Magazine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be flie Department of Health and Mental I Important: If item 27 is marked o Shirley Ann Wilkinson Franklin Terril Jones, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Boones Drive, Lothian, Md. 20711 Donald Cole - Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c, Location - City or Town, State 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 9/24/2010 Hagerstown, Maryland Park Lawn Mem. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Wilson Blvd. Hagerstown, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 787B Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No s been signed by the should be detached 9 Unknown 9 Unknown P.O. 23e. Did tobaccouse contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Pa Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? performe Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical examine?

1 Yes 2 No **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? iniury Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 2 No ☐ Accider ☐ Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man∮er as stated.

↑ (Check only one) 29b. Signature and (i 29d. Date signed 30. Name and address of person who completed 83 9 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl 3. Time of Death Month Year Physician/ PABLO VILLACIS 2010 929 CM Α. 09 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MEDILAL CENTER BALTIMORE CF MARYLAND University If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗙 M 2 🗌 F December 18, 1932 Ecuador 77 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1

Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2656 Cameron Way 21701 Ecuador Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 No If Yes, Give Specify: white Ecuador Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chauffeur Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Fernando Villacis Luz Maria Perez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pablo Villacis, Jr. - son 2105 Graystone Court, Frederick, Maryland 21702 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XX remation 3 Removal from State Stauffer Crematory 9-20-2010 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility yre of Funeral Service Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicianz Interstitual Lung Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ARDS -tran that initiated events resulting in death) Last and Due to (or as a consequence of): the bunial attending physician Physician/Medical as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant 9 Unknown Pregnant at time of death i signed by the ail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3, ☑ Probably 4 ☐ Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 2 perform 1 ☐ Yes 2 No certificate Yes 2. No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🗖 No 1 Minpatient 2 ER/Outpatient 3 DOA ျပ 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 ☐ Yes 2 ☐ No Matural Natural 5 Pending Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 3 E 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 518080186 Inces le Jussal 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201-1595 JASSAL BALTIMURE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Physician/ Month Colonel J. T. Vaughan Jr. Seotember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges **Examiner** Doctors Community Hospital Lanham MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 05/28/1933 Director 236-46-3563 Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No MD Prince Georges Lanham 10f. Zip Code items 23a or ner must be n 0 10e. Street and Number 10g. Citizen of What Country? Funeral US 6941 Emerson Street 20784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or ite Armed Forces?
1 IX Ves 2 □ No
If Yes, Give
Year or Dates. 01 / 1953 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postal Supervisor Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hy.
Important: If item 27 is markany injury or other ** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha McDaniel Colonel J. T. Vaughan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patty P. Vaughan spouse</u> Emerson St. Lanham. MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/24/2010 Cheltenham, MD Cheltenham Signature of Fune al Ser 22. Name and Address of Facility Philip D. RinaldiF.S., PA Blvd., Columbia Silver Spring.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laiters. List only one cause on each in. Accident Onset and Death Immediate Cause (Final 2 ehrovascular 0 Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ng physician and as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Year 2 🗆 No signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by alian eumonis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Valeula DISEARE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1. Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 48213 Ŋ 09-16-2010

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month Day, Year)

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Division of Vital Records, P.O. Box 68760

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. Registrar's Signature

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andover Hills MD 20784.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER Day 4 2010 ROGER WHITLEY 9:00 AM M Medical n. Facility Name (if not institution, give street and number 16107 VILLAGE DRIVE WEST 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER MARLBORO PRINCE GEORGE Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Yea March 20 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. **Funeral** Hours 1 🕱 M 2 🗆 F Smithfield NC Director 243-46-4845 1936 Usual Residence of Decedent fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director MD PRINCE GEORGE UPPER MARLBORO XX Yes 2 No 28a-f 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 20772 US 16107 VILLAGE DRIVE WEST items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 L Black, White, etc P ģ 1 Never Married 2 X Married 1 X Yes 2 No. 1955-1957 Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) OGEN AVIATION SERVICE permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic. avon* the 12 or 12 or 13 or 14 or 14 or 15 or 14 or 15 Elementary/Seconday (0-12) College (1-4 or 5+) 12 BUS DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAMS ROGERLENE PERCY **EDWARD** WHITLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UPPER MARLBORO MD 20772 16107 VILLAGE DRIVE WEST DORIS C. WHITLEY - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept 20 201 DCHELTENHAM MARYLAND MARYLAND VETERANS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility POPE FUNERAL HOME 20747 5538 MARLBORO PIKE FORESTVILLE Part 1. Enter the diseas , of complications that caused shock, or heart failure. List only one cause on each line 23a. Part 1 , of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition morea Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death
9 Unknown 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 🔽 Division of Vital 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital: Other: ဨ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 29c, License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

31. Date filed (Month, Day, Year) SEP 2 3 2010 028041

9654 MARLRORE PILCE UPPER MARCHORE IND 20772

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 17, Physician/ Louise Williams 2010 8:52 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Suitland 4140 Suitland Road Apartment 402 5. Social Security Number Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Days Hours 1 M 2 X F 90 8/11/1920 579-28-4126 South Carolina Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Maryland Prince George's Suitland 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 U. S. A. 4140 Suitland Road, Apartment 402 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3X Widowed 4 ☐ Divorced Year or Dates American 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) High's Convenience Elementary/Seconday (0-12) College (1-4 or 5+) Store 6 Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Hibler Arthur Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14103 Kendalwood Drive, Upper Marlboro, MD James E. Lewis/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or otl 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 9/25/2010 Suitland, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ORONAR EART disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlansit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Year Month Day Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy MF 1 🗌 Yes 2 🗌 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 🔀 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury M Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident

Registrar

State

Medical

Shantha K. Murthy, M.D., P.C. 6196 Oxon Hill Rd., Suite 520, Oxon Hill, MD Registrar's Signat

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD-70024062

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

20745

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

29b. Signature and title of certified

31. Date filed (Month, Day,

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No. Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Day Winston Physician/ Year 0732 nice September 3010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death General Hospital Howard County Columbia Howard Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/28/1956 **Funeral** 1 M 2 XF Days 417-84-9283 Director 53 Michigan Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard 1 Yes 2 X No Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 4720 Rams Horn Row 21042 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NSA Computer Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Jack Siersma Jean Boik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurence Winston - Husband 4720 Rams Horn Row Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Ardent Crematory 09/21/2010 4 Donation 5 Other (Specify) Hanover, MD 21. Sign were of Emeral Vervice Licenses 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 ax MOIYI 23a. Par 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Atherosclerotic coronary vears Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Que to for se a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No ☐ Pregnant at time of death ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Diabetes Completed 1 Yes 2 No 3 Probably 4 Unknown peen s Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has Yes 2 No 1 Yes 2 JaNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: |은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) . Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No. within 24 hours after death.

To the Funeral Director: All completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner; only one) 29b. Signature and title of certi September 18, 2010 DØØ53312 MAS

Registrar

DHMH 17 Rev 7/2009

State

HCGH

755 Cedar Lane, Columbia, Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Redistrar's Signature

Henggeler

Michelle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SEPT. Year Physician/ 09/2 Alberta M. Wise 2010 . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICONICO REGIONAL SALISBULL TENINSULA 9. Birthplace (State or Foreign $V \stackrel{c}{A}^{ountry)}$ 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🛛 F Min. Days 7 (Manth, Pay Year 210-22-5088 89 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Withams VA Accomack 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6657 Neal Parker Road 23488 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4X Divorced Specify: Black Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Security Officer Ukn Rutgers University and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Lee Holden Bertie Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 360 Crums Church Rd, Berryville, VA 22611 Frederick Wise, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of Cem cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Independ 9/25/2010 Withams, VA Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause an each line Immediate Cause (Final Physician/ HERD SCLEFOTIL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exami death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physiciar Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🛛 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? s after death.

I Director: Aft d in by the fur 2 🗌 No 1 Tyes 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

of Vital

Division

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Devan	1	Walls	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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n, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Mar	rried 12. Was Decedent Armed Forces?	?		is Decedent of F es, specify Cub				- 14. Race - White,		Indian, Black,
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Baltimore, permit. Pages 1 at Department of He Important: If ite		1 XBurial 2 Cremation 4 Bonation 5 Other Spe	_	ale	crematory or oth		a	0 27_	2010	Hebron	мт	D.
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Dan		30. Name and address of person w Pamela E. Southall, MD			•	1 Penn Stree	et Baltim	ore MD 2	1201			
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DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert G908 10/22/10 dk
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Fernglen C. Wiherle 2. Date of Death Physician 89-21-28 TO 1455 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harkord Havre de Grace 4 Hopewell Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06 - 17 - 19 28 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕡 F Pennsylvania 82 213-26-9343 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examiner must be rediffed at once. 1 □Yes 2 No Director Havre de Grace Maryland Harkord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 4 Hopewell Road 21078 by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ∐Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (4-4or 5+) Realtor Realtu 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blair Carper Iva Hile ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 706 Pulaski Highway, Havre de Grace, Maryland 21078 Cecil F. Hill, Sr. (executor) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RA Ferris & Co Inc, 09-24-2010 West Chester, Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 Ture of Funeral Service Licenses 123 S. Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Metastatic Non Sma Physician /Medical Due to (or as a consequence of): Examiner Seques itself list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐N6 sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital o 24 hours af e Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the

Division of Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Mae Josephine Worsham 7:44 Рм September 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hyattsville 4004 Hamilton Street If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** Months Hours 1 M 2 X 8 Washington, 579-34-3424 Director 82 1928 May Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 4004 Hamilton Street 20781 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanić Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 K No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher's Aid 12 should be file and Mental H is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Vincent Purdy Catherine (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a Kenneth E. Worsham Husband 4004 Hamilton Street, Hyattsville, MD 20781 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or otl 1 X Burial 2 Cremation 3 Removal from State 9/22/2010 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Mass disease or condition Months Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, Directo (or as a consequence of) If any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Shortness of Breath and -tran Exal Due to (or as a consequence of resulting in death) Last burialattending physician I for use as the buria Physician/Medical Congestive Heart Failure Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death the 9 Unknown Division of Vital Records, P.O. ò Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has autopsy performed?

1 Yes 2 No Atrial Fibrillation certificate 1 ☐ Yes 2 ☐ No Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 Tyes 2 🔀 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 X Natural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Chevonne T. Salmon,

2 2010

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Sigratu

29c. License number

6525 Belcrest Road, #160, Hyattsville, MD 20782

D67611

29d. Date signed (Month, Day, Year)

9/21/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 9 2010 1933 MICHAEL WORKMAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner <u>Prince Georges</u> Southern Maryland Hospital Clinton Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral Days 1 🖾 M 2 🗆 F Months Hours Min. (Month, Day, Country) Director 52 577-76-8901 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD Prince Georges Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4321 Telfair Blvd. #D203 20746 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 7 97 1 Yes 2X No Specify. Specify: 3 Widowed 4 Divorced 1984 Completed **Black** Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 11th College (1-4 or 5+) unemployed None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown Mary Workman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verna Workman - wife Telfair Blvd. #D203 Camp Springs, MD. 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 9-22-2010 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Marshart Marchill Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ... ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events death certificate be executed resulting in death) Last physician a s the burial-Completed by Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy 2 No 1 TYes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number dress of person who completed cause of death (tem 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)
SEP 2 2 2010

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

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Funeral	Г	5. Social Security Number 6. Sex 7. Age (I	n yrs. last birth	day) If Under 1	1 Year	If Under 24 Hrs. 8	B. Date of Birth	h	g. Birth	place (State or Foreign
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ary pould nd Me mari		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street a	nd Number or Rural Fi		City or Town	State Zin	Codel
Mal d 2 shor alth and alth and 27 is n		Daron Ward - son	•			d Lane, F		•		,
of Her		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of [Disposition (Name crematory or oth	e of	Dat		20c. Locatio		
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Dartimore, IMaryliand Z1Z13-UU30 permit. Page 1 and 2 should e filed within 72 hours after death with the Maryland Department of Health and Minntal Hygiene Important: If item 27 is man ed other then "natural", or items 23a or 28a-f show any highry or other traumati. event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22. Name and	Addres	s of FacilityEter	nal F	aith	Funer	al Sv
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W. Carrier		shock, or heart failure. List only one cause on each line.				, such as cardiac of h	espiratory arre	#SI,		Approximate Interval Between Onset and Death
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or At or At after of Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury building, etc. (\$	- At home, farm Spec <i>ify)</i>	n, street, factory, o	office	28	f. Location (St City or Town		nber or Rura	Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the best	nination and/or i	investigation, in my	y opinior	, death occurred at the	e time, date ar	nd place, and	due to the ca	use(s) and manner stated.
To the Control	_	29b. Signature and title of certifier		29c. L	License	number	2	29d. Date sigr	ned (Month,	Day, Year)
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month Ronald William Walters 7:30a Sept Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours July 20, Year 38 72 Kansas Director 510-36-4523 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 20905 United States 609 Mission Hills Court items ? hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. African , or 1 Never Married 2 X Married þ Maryland 21215-0036 1958 1 Yes 2 No Specify "natural" Completed 3 Divorced 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Professor **Howard University** Ith and Mental Hygien 27 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maxine Fray Galmar Walters permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Mission Hills Court, Silver Spring, MD 20905 Patricia A. Walters/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of 09/20/2010 | Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last that the death certificate be exec Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🗶 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h perform 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2**X** No 1 Yes Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60168 10 September 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rad, Sit III, forevel, mis 20854 ASEFA MEKONNEN,

State Registrar

31. Date filed (Month, Day, Year)

2010

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Sever houces

1201

MRS State Registrar 29b. Signature and title of certifie

Qamar U. Zaman, M.D.,

29c. License number

D0023371

12502 Willowbrook Road, Suite 440, Cumberland, MD

29d. Date signed (*Month*, *Day*, *Year*) SEP 16, 2010

21502

and manner stated.

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31387 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William T. Willison Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Western Maryland Regional Medical Center Cumberland 5. Social Security Number 8. Date of Birth (Month, Pay Year), 1930 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 - F 215-26-6389 80 Covitavland **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** Maryland Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 123 Columbia Ave 10f. Zip Code 10g. Citizen of What Country? 21502-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status le 1 and 2 should be filed within 72 hours after deat t of Health and Mental Hygiene. If item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner I 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Mechanic Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Edith Willison Thomas Willison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 3219 Ye11ow Row Rd. Mount Savage Maryland 21545 Debbie Blair daughter 13219 Yellow Row Rd. Mount Savage 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1:
Department of I
Important: If ite
any injury or ot
once. cemetery, crematory or other place) Cumberland Crematory September 23, 2010 Cumberland 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RUNAL DISCASE MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) ned by the attending physician and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by OFNONIC OBSTRUCTIVE PULMONTRY METASE 1 Yes 2 10 3 Probably 4 Unknown CORDNMEY HATTRY DISCHEE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed this certificate Yes 2 L 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 1 M6 Hospital: Other: 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the nospran.

Within 24 hours after death.

To the Funeral Director: After this 27. Manner eath Certificate: 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) atural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Confliging Nurse Practioners To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and incriner as stated 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) DAYSICAN D50844 2010 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar
DHMH 17 Rev 7/2009

LOVERIA JZ, MD

32. Registrar's Signature

JOSE

912 SETONDRIVE CUMBERGAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09/ Physician/ Edmond R. Whitehead Day 14/2010 8:40 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Charlotte Hall St. Mary Calway Age (In yrs. last birthday) 8. Date of Birth (Month, Day, March 30, Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 238 42 6354 North Carolina Director Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 No Charlotte Hall Maryland 1 St. Mary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Road 20622 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces
1 V Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2xxx No Specify. White 3 XXWidowed 4 □ Divorced WII Specify: Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important. If item 27 is marked other than "any injury or other traumatic event, the Med once. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Mail Distributor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stella Mae Jackson UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Costuros (Daughter) 9809 Emerald Lane, Newburg, Maryland 20664 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Maryland Veterans Cemeterly Sept 24, 2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria of Funera Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final CAT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a 11, leading to immediate cause. Enter Underlying Examiner Due to for sella consecuence of M the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) HOSPICE 1 🔲 Yes Other: 2 10 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec this To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Dr. Schmidt, 40900 Merchants Lane, Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 15, 2010 15:05 P M Grady Willis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Georgia 8. Date of Birth (Month, Day, Ye Sept. 24 **Funeral** 7. Age (In yrs. last birthday) Days Hours 1 🛛 M 2 🗆 51 Director 577-80-4620 Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Camp Springs 1 🛚 Yes 2 🗆 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6006 Old Branch Avenue 20748 United States "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates and 2 should be filed within 72 hour. Health and Mental Hygiene. Item 27 is marked other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10 years College (1-4 or 5+) Roofer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie Ed Willis Geneva Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 2349 Green Street SE # 204 Washington, DC Latoya Simmons - Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) ☐ Burial 2 XCremation 3 ☐ Removal from State Lee's Crematory 4 ☐ Donation 5 ☐ Other (Specify) Sept 22, 2010 Clinton, Maryland 22. Name and Address of Facility Stewart Funeral Home, ture of Funeral Service 4001 Benning Road NE Washington, DC 20019 23a. Part 1 the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Signar tielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed PIRATORY that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Month Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗆 Yes 2 No ပ္ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending s after death.

I Director: After in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours

To the Funeral 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifier erson who complete use of death (Item 23a) (Type, Print) SURPATTS 0 503 Date filed (Month, Day. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ I3, Willie Mae DeVaughn Washington September 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Rehabilitation Center Fort Washington Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | Min. | March | Z, 1926 Social Security Number 9. Birthplace (State or Foreign Country)
South Carolina **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1 🗆 M 2 🔀 84 Director 579-54-9110 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12021 Livingston Road 20744 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 72 hours after 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3 X Widowed 4 Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) 5th College (1-4 or 5+) Nursing Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arminous Devaughn Georgia Ann Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Der artment of Health ar Important: If item 27 is any injury or other trau once. Apt. # 1 Washington, DC 20002 508 M Street NE Gloria Williams - Daughter Date 23, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 2010 Harmony 22. Name and Address of Facility ture of Funeral Service Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part De ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final -Physician/ Atherosclerotic Cardiovascular Disease disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ner Due to (or as a consequence of) Exami the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\sum \) Yes 2 \(\overline \) No Month Day Year Pregnant at time of death 1 Yes 2 to 9 Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 🗆 Yes

Maryland 21215-0036 Baltimore, or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate has ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 🔼 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Funeral Medical 29a Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18545 September 16, 2010 20602 erson who completed cause of death (Item 23a) (Type, Print) Philip Wisotsky, M.D., F.A.C.P. 12070 Old Line Centre, #207 Waldorf, Md. 31. Date filed (Month, Day, Year) 32. Regisear's Sig State Registrar DHMH 17 Rev 7/2009

State Registrar

DHMH 17 Rev 1/2001

11110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's

41667

Compro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year MARY 9:00 PM BLACK OCTUBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE CITY HARBOR HOSPITAL BALTIMORE Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 💢 F OCT 4, Pay, Yang 21 214-12-5735 89 Yrs. Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f show any injury or rother traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 901 Phylen Court 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Assembly Line Worker Can Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Sedlmayer Ella Elizabeth Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Kuykendall, daughter Shrewsbury, Pennsylvania 17361 3 Foxtail Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/07/10 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. George MacNabb EMME 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician REMAL ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine EPS IS Il or Attending Physician: The law requires that the death certificate be executed birectoral. After this certificate has been signed by the attending physician and birector. After this certificate seen signed by the attending physician and in by the linearial director, page 2 should be detached for use as the burnal-transif Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical STAGE DEMENTIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Rhabdomyolysis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a, Was an 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕱 No Other: 욘 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined Hospital c 24 hours at Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F 29b. Signature and title of certifier RES OOL RESIDENT - PHYSICIAM OCTOBER 5

State Registrar ADITYA S
31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

HARBOR HOSPITAL, 3001 S. HANOVER ST. BALTIMORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AMEND #30 PER DVR G908 10/07/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician/ 1d NA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month Day, Hours Min. 1 X M 2 - F Maryland Director 235-46-3417 77 Dec Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1604 Heathwood Road 21061 **IISA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 ☐ Never Married 2 X Married X Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify. Specify.white 3 Widowed 4 Divorced 152-55 Year or Dates unk unk 16a. Decedent's Usual Occupation UN (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Opal Pearl-Kay Thompson Basil Bertell Bartlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Heathwood Road Glen Burnie, MD 21061 Joan Bartlett/spouse 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Ronald 28 Partend Address of Byllit Board 655 W. Baltimore Street MD21201 23a. Part I. Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) M M3dings Medical Examiner 13m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown cate has been signated to said Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To I 1 Tyes 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending work 1 🗌 Yes 2 🗌 No ☐ Accident Investigation

Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lakeshore Physicans 4231 Postal Ct Ste 102 Pasadena, MD 21122

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

OCT 0 7 2010

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ OUTOBER 2 000 2:09 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL BALTI RAND TONN Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Months Days **Director** 21.3-82-2335 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9612 Antler Circle 21133 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African-American Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Iron Worker Security Vault Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any njury or other traumatic ev be Oneal Burgess Hattie Mae Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Mae Wigfall/Sister 4310 Brookview Terrace, Fort Washington, MD 20749 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 10-11-2010 Baltimore, MD 4 Donation 5 Other (Specify) Sign ture of Funeral Service Licens 22. Name and Address of Facility Wile Funeral Forc P.A. of Falto. Co. 9200 Liberty Road, Randallstown, MD 21133 rd. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between ATHERO SCLEROTIC mediate Cause (Final Onset and Death CARDIOVASCULAR Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? been signed by the atte should be detached for Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has After this certificate 1 ☐ Yes 2 ☑ No Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 | No 은 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) er of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State Registrar OUD COURT

of death (Item 23a) (Type, Print)

401

(M)

31. Date filed (Month, Day, Year)

29c. License number

2010

4GTOWN MARY LAND 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23a State of Mary 908, 1090 The Bealth and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 **Physician** Month Doretha Sep. Belin 16. 2:00 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jul. 26, 1963 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min 250-43-4233 Director 47 Washington, DC Usual Residence of Decedent death with the Maryland 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evaminar coust be notified at Director 1 MYes 2 □ No Maryland Prince George's Hyattsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4922 Lasalle Road USA Funeral 20782 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No If Yes, Give Year or Dates: Specify \$ 3 ☐ Widowed 4 ☐ Divorced Specify: Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within Elementary/Secondary (0-12) College (1-4or 5+) 12 h and Mental Hygie Marriott Hotel House Keeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked c any injury or other traument. Doretha Jackson Sam Belin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29161 Diane Belin (Sister) 1617 Meander Dr., Timmonsville, SC 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-28-2010 Alexandria, Virginia Crematory utur of Funeral Service Licensee 22. Name and Address of Facility Ideal Funeral Parlor, Inc. 106 E. Darlington Street, Florence, SC 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Hypertension sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 ☐ Other (specify) ned by the a detached if 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 a autopsy performed? certificate 2 1 NO 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2. NO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this in by the funeral 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28d. Describe how injury occurred 1 -1 atural 5 Pendina after death 2 Accident investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060100 MO

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA 13LUD

37. Registrar's Signature

University

OCT 07 2010

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of certifier

MsRajapalise M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rakupa KSR/MID. 2835 Swith AN. S. 203, Baltimore

. Registrar's Signa

29c. License number

DO057 46.5

29d. Date signed (Month, Day, Year)

9/27/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Octonth 5^{Day} 20109ar 1:20 A William Bauer, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death College Manor Lutherville Baltimore If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-18-1560 1 ★ M 2 □ F 86 Davs Hours Mar. 29 Yel 924 Mar VI and Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 508 Piccadilly Road U.S.A. . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Completed by 1 Never Married 2 Married 15 Yes 2 No If Yes, Give 1943–46 Year or Dates, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: id Mental Hygiene. marked other than "natural", Specify: White 3 K Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (7-4 or 5+) Engineer Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Frederick Bauer, Sr. Edyth Cathyrn Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 William F. Bauer, III / Son 508 Piccadilly Road Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Cdns 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1X Burial 2 🗌 Cremation 3 🔲 Removal from State 10-11-2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or semelications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final End Physician/ disease or condition resulting in death) 5Tage Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 Pregnant a Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

ouwe

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3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number 02473

west

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1705 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Howard County General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Months Hours (Month, Day, Year) Mar 10, 1926 Country) Unknown Director 217-22-0094 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore** Maryland **Baltimore City** 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 908 Nottingham Road 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify: Black If Yes, Give Specify 3 □ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MTA Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9180 Rumsey Road - Unit 2 Columbia, Md. 21045 Necol Hite Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/05/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park . Signat neral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PTIE Shock disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BACTERIMIA Sequentially list conditions. Examiner it dry, leading to infractiate cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and defeated for use as the burial-transit STAGE RENAL the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VASCULAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

Jeral Director: After this certificate has if illed in by the funeral director, page 2 to the funeral director. autopsy performed 1 ☐ Yes 2 DNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital ٥ 1 🗌 Yes Other: ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Spor MO 00053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD X Shaleun male fupre 9650 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland		artment of F tificate of L		ind Me		2	010	31399	
	Registrar 1. Decedent's Name (First, Middle, Last)					2.				2. Date of Death 3. Time of			3. Time of Death	
		Physician/ Medical Frank Lyn Boyce, Jr									September 24, 2010 8:11 P			
	Examir	er	4a. Facility Name (if not institution		own, or Location of Death			4c. County of Death Baltimore						
4	Funeral		7 Harmony Mill 5. Social Security Number	6. Sex 7. Age	S. Sex 7. Age (In yrs. last bi						8. Date of Birth		thplace (State or Foreign	
	Director		212-50-2773	1 🖾 M 2 🗆 F	63	Yrs.	Months Days	Hours	Min.	12/18/	1946	Ma	ryland	
	and show at	or	Usual Residence of Decedent 10a. State 10b. County	у	10c. City, 1	Town or Loc	ation						10d. Inside City Limits	
	Maryla 28a-f s otified	rect	MD Balt	imore	Cato	nsvil	.le						1 ☐ Yes 2 🔣 No	
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	ath wi	Funeral Director	7 Harmony Mil	1 Court	ver in IIS	13 V	21228 Vas Decedent of H	ispanic Origi	n? (Specif	v Yes or No-	U.S	A. 14. Race - Ame	orioon Indian	
9	ter de , or its imine	by F	1 ☐ Never Married 2 🛣 Mar	Armed Forces?		If	Yes, specify Cuba	n, Mexican,	Puerto Rio	an, etc.)		Black, Whit	e, etc.	
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7	72 he an "na Medic	Completed		ent's Education nest grade completed)		(Give k	ent's Usual Occup ind of work done o NOT use retired)	ation during most o	of working		16b. Kir	nd of Business	Industry	
2	l withir ygiene her tha t, the		12	College (1-4 or 5+	+)	Arc	hitect				C	Constru	ction	
and	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, I							First, Middle, I	Maiden S	, _		
ary	nd Me nd Me s mark		F'rank Lyt 19a. Informant's Name/Relations		J	19b. Mailin	g Address (Street a	Oliv		P.	City or	Tayl		
Σ	nd 2 sh ealth a n 27 i ier tra		Brenda Boyce /	/ Wife			mony Mil			•	,			
ore			20a. Method of Disposition 1 Burial 2 Cremation	3 □ Removal from State	20b. Plac	ce of Dispos netery, crem	sition (Name of atory or other plac	e)	Dat	е	20c. Lo	cation - City or	Town, State	
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once,		4 ☑ Donation 5 ☐ Other (S		Anato		ts Registr						aryland	
Ba	Depi Impe		* SOF	Elicerise								~	MD 21076	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	or complications that caused to carry one cause on each line.	the death. [Do not enter	r the mode of dying	g, such as ca	ardiac or re	espiratory arre	est,		Approximate Interval Between	
- 7	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)				in cance	r with	lun	g meta	stas	is	Onset and Death	
	Examiner		resulting in death)	Due to (or as a	consequen	ice of):								
		iner	Secus tially list conditions if any, leading to immediate cause. Enter Underlying	consequen	onsequence of):									
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	ate be executed physician and the burial-transit	edical E	resulting in death) Last	Due to (or as a	consequen	ice oi).								
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× 68	death certificate be executed he attending physician and ed for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		Petal d	eath 3 🗌	Ectopic pregnanc	у			2	3d. Date of de		
. Box	he dea y the a ched f	nysic	1 Yes 2 No	4 Pregnant at 9 Unknown	time of dea	ith 5 ∐	Other (specify)					Month	Day Year	
J.	that the	by P	Part II. Other significant condition	ons contributing to death but	t not resulti	ing in the ur	derlying cause giv	en in Part I.		23e. Did tot	oacco us	se contribute to	the cause of death?	
rds,	equires een siç ould b									1 🗆 Y	es 2	No 3□P	robably 4 🖔 Unknown	
Vital Records,	has by	Completed								24a. Was a autops perfori	SV		topsy findings available completion of cause of	
ř	an: The tifficate or, pag	Be Co	25. Was case referred to medical				26 Pla	ace of Death	(Check or	1 Yes	2 X No	1 ☐ Ye	s 2 🗆 No	
<u> </u>	hysicia nis cer I direct	10 B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 🗆 ER	l/Outpatient	Othe	ar.		· · · · · · · · · · · · · · · · · · ·	ence 6[Other (Spec	ify)	
10 L	ding Pl		27. Manner of Death1 X Natural5 □ Pendin		Year) 28	lb. Time of injury	28c. Injury work	?		I. Describe ho	w injury	occurred		
DIVISION	Attendar death	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be	y - At home	e, farm, stree		Yes 2 N		. Location (St	reet and	Number or Ru	ral Route Number,	
≥	tal or irs afte al Dire		4 El Homiciae acterni	building, etc.	(Specify)				1,1	City or Town				
	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical E	g Physician: To the best of m Examiner: On the basis of exa g Nurse Practioner: To the be	amination ar	nd/or investig	gation, in my opinio	n, death occu	urred at the	time, date an	d place,	and due to the	cause(s) and manner stated.	
	29b. Signature and title of certifier 29c. License number 29d. D							9d. Date	signed (Monti	h, Day, Year)				
	•		30. Name and address of person	Who completed cause of dea	ath (Item 23	Pa) (Tupo Pr	D2-6	880			16	14/10		
		_	11 / 77	ris 300 Ams	,	love	Suite	30	Bu	lot. In	n.l.	2/20)/	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registar		,	,							
			001(VICUIU The	44	B	1							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month . 45 P .M Year Brown Annie October 2010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death esaco 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Director or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 Xo 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry DO NOT use re College (1-4 or 5+) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signatur of Fine II Sarvio Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Lung Cancer Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Uause (Disease of impury that initiated events resulting in death) Last signed by the attending physician and deed be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 \square Yes 2 🗌 No Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MsRajapahlM-D 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N - 5 , Ray PAUCL MD 2835 Smith 5-203, Balamore, MD. 21205 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23 23 2010 2:05 РМ Lloyd Cauthorne Jr. August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 903 Saratoga St; Apt 1 Baltimore 8. Date of Birth (Month, Day, Dec 23, 5. Social Security Number unk 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday, Days Hours Min 1 ☑ M 2 □ F Director 65 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show MD 1√ Yes 2 □ No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 903 Saratoga Street #1 21223 USA death v 12. Was Decedent Ever in U.¶ank Armed Forces? 1 □ Yes 2 □ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or iter Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: black 3 Widowed 4 Divorced other traumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ofcr Bywaters Baltimore City Police Dept Baltimore, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: if ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Mother (Specify) in starte Funeral Service License Signal 22. Name and Address of Facility State Anatomy Baltimore, MD Board 655 W. Baltimore Street Ronald Approximate Interval Between Onset and Death Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a heart failure. List only one cause on each line. 23a, Part 1 Immediate Cause Final disease or condition **Physician** YEAR resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, from class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami burial-tran Due to (or as a consequence of) P.O. Box 68760, physician death certificate be Physician/Medical the as IF FEMALE ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 D Ectopic pregnancy Por Month Day Year Pregnant at time of death signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ≥ 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □ Yes 2 certificate 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 20 No Hospital: 1 ☐ Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Division **Natural** 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled curtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 1 Actriffying Physician: To the best of my knowledge, deam occurred at the time, date and place, and due to the cause(s) and make and place, and due to the cause(s) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State Registrar

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 11 13 AM **Physician** James Carroll Comer Sr, 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ballimore FRANKLIN Sauare Hospital Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June2, 1935 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1X M 2□ F 231-38-7204 75 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Baltimore Middle River 1 □Yes X□No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21220 USA 4 Mango Trl items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: White 3 □WVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Beth Steel 12th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Comer Irene Grimsley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie McDonaldson 39 Cool Breeze Baltimore MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 10/5/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neutropenic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cell Carcinoma Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure respiratory 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Failure Anemia 24a. Was an autopsy perform ce ificate 2 No 1 ☐Yes 2 ☐ No 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who

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P.O. Box 68760

Records,

Vital

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Division

completed cause of death (Item 23a) (Type, Print)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

124846

4000 FRANKLIN Square DR Balto Md 21237

10-01-2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1442 2010 Medical 4a. Facility Name (if not institution, City, Town, or Location of Death 4c. County of Death **Examiner** of Wary bud Baltimore City University 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 4-12-1941 Months Days Hours 216-60-7340 Director 69 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 🗆 No MD Baltimore na 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ò Funeral "natural", or items 23a 108 Larue Square 21225 U S Α Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No Never Married 2 Married Black, White, etc. \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Rest Horn & Horn life. DO NOT use retired) Elementary/Seconday (0-12) 6th grade College (1-4 or 5+) Bus Girl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked or permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve P Roy Cole Mildred Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Cole -Father 108 Larue Square Balto, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 10-7-2010 Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical s a consequence of Examiner 27 hours Sequentially list conditions Examine daily, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Date to for as a consecution Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year 1 ☐ Yes ∠ y 9 ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? trausplant 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed yputeusion 2 🗌 No Yes 2 N 1 Yes 25. Was case re e red to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other 1 🗌 Yes 1 Anpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Deertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier R107416 0105/2010

Registrar

State

31. Date filed (Month, Day, Year)

Baltimere WD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharou Boswell, CENP ZZ S. Greene St.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	arylan		artment of H tificate of D		Mental Hy	giene Reg. No.	010	31405			
*	Physicia Medic	al		mbala					2. Date of De Month.	n Day	200 200	3. Time of Death 23:52 PM			
	Examin		4a. Facility Name (if not institution Johns Hopkins 5. Social Security Number	Sayview Mar		Certer ast birthday)	4b. City, Town, or Baltin If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	nty of Death N/A g. Birthp	place (State or Foreign			
	Director		219-05-4272 Usual Residence of Decedent	1 □ M 2 🖾 F	91	Yrs.	Months Days	Hours Min.	APR. 2	20, Year) 191	9 Coun	OHIO			
	faryland 8a-f shor tified at	ector	10a. State 10b. County MD BALT	MORE	10c. City	y, Town or Loc DU	ation NDALK				1	0d. Inside City Limits 1 ☐ Yes 2 🙀 No			
	ith the N 23a or 28 st be not	Funeral Director	10e. Street and Number 2704 MOOREGATE				10f. Zip Code	21222		0	of What Cour	,			
920	should be filed within 72 hours after death with the Manyland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	۾	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?			/as Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. [Race - Americ Black, White, cify: WHI	an Indian, etc.			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once.	Completed		nt's Education st grade completed) College (1-4 or	5+)	(Give k	ent's Usual Occupa ind of work done do NOT use retired) CLERK	ation uring most of wor	king	1	of Business Ind				
73	should be filed wir and Mental Hygie 7 is marked other raumatic event, the	oo ŀ	8	17. Father's Name (First, Middle, I SVEN OJA			<u></u>		18. Mother's Nar	ne (First, Middle,	Maiden Surn				
	d 2 shoul alth and I alth smi 27 is mi er trauma		19a. Informant's Name/Relations CATHY PONIATOV			1	g Address (Street a DENTON WA		ral Route Numbe		ın, State, Zip (L009	Code)			
altimore,	Page 1 and ment of Her ant: If item ury or othe		20a. Method of Disposition 1 □ Burial 2X Cremation 4 □ Donation 5 □ Other (\$	3 Removal from State		emetery, cren	sition (Name of natory or other place CREMATOR)	OCT.	Date 6, 2010		ion - City or To	wn, State MARYLAND			
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service I	icensee			Name and Addres								
8	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and in positive completed filled in by the funeral director, page 2 should be detached for use as the burial-transit at Page 1.	disease of condition										Approximate Interval Between Onset and Death			
09		/Medical Exami	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Prem Due to (or as								2 Days			
. Box 6876			ıysician/Medi	ıysician/Med	ıysician/Med	nysician/Med	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Feta	al death 3 🗌	Ectopic pregnancy Other (specify)	У		23d.
s, P.O.	res that the signed by a be deta		Part II. Other significant condition	ons contributing to death	out not res	ulting in the u	nderlying cause give	en in Part I.			contribute to th	ne cause of death?			
Records,	ne law requir te has been a age 2 should	Completed by							24a. Was auto perfe 1 □ Yes		4b. Were autoperior to condeath?	psy findings available mpletion of cause of			
Vital	ysician: is certifica director, p		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ient 2 🗆	ER/Outpatien	Othe	r: 4 \(\sum \) Nursing H			Other (Specify)			
Division of Vital	anding Ph aath. rr. After thi	Certificate: 7	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi	g 28a. Date of injuge (Month, Date of injuge)	iry	28b. Time of injury	28c. Injury works M 1 🗆	at	28d. Describe						
Divisi	tal or Attors after de al Directored in by t		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ				et, factory, office		28f. Location (City or To		ımber or Rural	Route Number,			
	he Hospi in 24 hou he Funer ipleted fill	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of Nurse Practioner: To the	examination	n and/or invest	igation, in my opinio	n, death occurred	at the time, date	and place, and	due to the car	use(s) and manner stated.			
	Not With Tot		29b. Signature and title of centife	X			29c. License	number S ー り のひ		29d. Date sig	gned (Month, I	Day, Year) 5 2010			
L			30. Name and address of person	who completed cause of a	leath (Item	23a) (Type, P		enne 13	altimor	e M	ID 21	224			
	Stat Registra	e	31. Date filed (Mon(h, Day, Year) OCT 0 7 20	\$2. Registr	ar's Signa	par par	les .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year COCHRAN ATHERINE 00:30 AM OCTOBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE JOHNS HOPKING BAYVIEW MEDICAL CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign June / Months Days 1 □ M 2 🖾 F Maryland 213-12-4904 Director 91 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Md. Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2825 Lodge Farm Road 21219 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 7th Factory Worker Factory Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elmer McDonald Mary Donahue 19a. Informant's Name/Relationship (Type, Print Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060Catherine M. Galek 7466 East Furnace Branch Rd. Glen Burnie,Md Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory: 1, 2010 Baltimore, Maryland 22. Name and Address of Facilitaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician RESPIRATORY disease or condition resulting in death) PATURE 5 HOURS Medical Due to (or as a consequence of) Examiner IWEEK PNEUHON.A Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury use as the burial-transi ATRIAL FIBRILLATION IWEEK that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗌 No ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗀 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопретен Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar mical querrong

NGUYEN

JESSICA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-TRONG

32. Regis rar's Signature

M.0

RES-000

4940 EASTERN AVENUE

OCTOBER 1

BALTIMORE MO 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9-28-2010 Physician/ 7:00 A M Ann Beverly Courtney Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Apt 206 8604 Wandering Fox Trail Anne Arundel Odenton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2x F Hours 1-20-1926 84 Director 257-20-6252 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No **Odenton** MD Anne Arundel ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21113 8604 Wandering Fox Trail USA Apt 206 items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Utilities Cooperative 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Meda Beatrice Hill James Beverly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2771 Price Road Crofton, Maryland 21114 Dau. Elizabeth Kyle Courtney Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State W. Arundel Crematory 9-29-2010 Odenton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Servic Livens ²²Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 M01176 t / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstuctive Luna Physician Chronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Stenosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ue to (or as a consequence of) Exami burial-transit as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be tera ascu eas use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) for 1 in the past 12 months?
1 Yes 2 No Month Year detached 9 Unknown P.O. signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 **N**0 မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Accident completed filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

only one)

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

888 Best

29c. License number 110005554

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryla State Registrar		artment of Heatificate of De			iene 0 1 0	31408	
	Obvojoj	on	Decedent's Name (First, Middle, Last)	Ci	2 11		2. Date of Deat Month	Date of Death Month Day Year 3. Time of Death		
	Medical As Escility Name (If not institution, give street and number)				nadha 4b. City, Town, or Lor		peptembe			
1	Examir	er	The Johns Hopkins Hospital		Baltimore C	ity				
	uneral rector		1.▼M 2□F	s. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02-20-	Year) C	nthplace (State or Foreign ountry) ndia	
			Usual Residence of Decedent	O'' T			02-20-	1900 1		
Marylaı	f shoved at	tor		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No	
th the	or 28a notifi	Director	MD Prince George's 10e. Street and Number	GTem	n Dale 10f. Zip-Code		11	0g. Citizen of What C	ountry?	
eath w	is 23a nust b	Funeral	6007 Glenn Station Court 11. Marital Status 12. Was Decedent Ever in	118 13		769	cify Ves or No-	United St		
)36 ırs after d	marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	Armed Forces? 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, № 1 Yes 2 No S	Mexican, Puerto F Specify:	Rican, etc.)	Black, Whi		
21215-0036 ed within 72 hours aft giene.	'natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done duri			16b. Kind of Busines		
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nd ? oe filed tal Hyg	d other	Be C	17. Father's Name (First, Middle, Last)		18	3. Mother's Name	(First, Middle,	Maiden Surname)		
Maryland d 2 should be file th and Mental Hy	and Ments is marked aumatic er	၉	Wazir Chand Chadha 19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and		n Kanta I Route Number		Zip Code)	
M 2 pt	f item 27 is marker r other traumatic e		Sunil Chadha / Brother	57	78th Street			•		
altimore, mit. Pages 1 ar	If item or othe		Bullar 21 Cremation 5 Inchiovar from State	. Place of Dispo cemetery, crer	osition (Name of matory or other place)	D	ate	20c. Location - City o		
Iltim nit. Pa artmen	Important: If if any injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22	2. Name and Address of	of Facility		Odenton,		
B P G	any and		Office I wastes	/ 1	Donaldson F 1411 Annapo	viic Road	1 Odento	an Marala	nd 21113	
		8	23a. Part 1. Enter the disease, or complications that caused the destrock for heart failure. List only one cause on each line.	ath. Do not ent	er the mode of dying, s	such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death	
) /Me	sician edical		disease or condition resulting in death) a. Due tr (or as a conse	equence of):						
Exa	miner	-e	Sequentially list conditions, if any, leading to immediate b Due to (or as a conse	editence off.						
uted	ansit	Examiner	Cause. Cities do or fight, y that initiated events	Addition only.						
o exec	physician and is the burial-transit		resulting in death) Last Due to (or as a conse	equence of):						
68760	g physic	Aedical	d						<u> </u>	
Box (eath cert	ttending for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of preg	etal death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year	
P.O. Hart the de	y the a	hysic	1 Yes 2 No 9 Unknown	death 5	Other (specify)					
cords, P.O. Box 68760, requires that the death certificate be executed	been signed by the attending should be detached for use a	þ	Part II. Other significant conditions contributing to death but not r	esulting in the ι	underlying cause given	in Part I.	23e. Did tol		to the cause of death? Probably 4 Unknown	
	e has beer age 2 sho	Completed					24a. Was ar autops perform	v / prior to		
/Ital	is certificate has b I director, page 2 s	Be C	25. Was case referred to medical examiner?			6. Place of Death				
- sk	this ce	은	27. Manner of Death 28a. Date of Injury	ER/Outpatien	f 28c. Injury at			ence 6 Other (Special Other)	ecify)	
SION anding ath.	r: After he fune	ation	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	M 1 ☐ Yes	2 🗆 No				
DIVISION or Attending lafter death.	Directo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
DIVISION C To the Hospital or Attending Pt within 24 hours after death.	e Funeral	Medical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.							
To th withir	6 00 ₽ E	Me	29b. Signature and title of certifier		29c. License nu	umber	2:	9d. Date signed (Mor	th, Day, Year)	
			30. Name and address of person who completed cause of death (It	tem 23a) (Tvn=	RES	000	5	eptember.	30 2010	
			Kenneth Tseng		<u> </u>	600 N	lorth Wol	fe St, Baltim	ore, MD, 21287	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 7 2010 32 Registrar's Sign	B. 40	all					

DHMH 17 Rev 1/2001

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AMEND ITEM#28b, perME, G908, 10/21/2010, WS

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#19b, 20a-c&22perFH, G909, 11/15/2010, WS

Certificate of Death

Reg. No. 7 State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month a Day 28 Physician/ D08524 Year 10 TAMMY 2. 14:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1504 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral unk 1 DM 2 D Months Days Hours Country) Maryland 43 Director 67 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nothers" any injury or other than "nothers". 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 1711 Abbotston Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify. black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation unk unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) q 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Tubman Cornela Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Anderson/uncle 2437 Maseil Court, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) in stat Bayview Crematory : 10/14/10 Raltimore, Board 655 Hari P. Close F.S. PA Baltimore, MD 21201 Ba of Fineral Strice Licensee TAI Baltimore Dimector 5126 Belair Rd. Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Approximate Interval Between or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death SUBDURAL HAMATOMA of LIGHT herriation Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** severe blood loss Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last NOVED BY MEDIC Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown icate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner: Hospital Other: <u>۾</u> 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 2020 jurpm 1 ☐ Natural 2 🔁 Accident 5 Pending pedestrian struck by motor vehicle 1 ☐ Yes 2 No 9/27/10 Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) politing FD and Dogwood palttmore, MC Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined street within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) AU 417 6435 9/28/10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Baltimore, MD . tz wofus . 2 41114 15m-Tan Hguyen 11 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ 4 Medical Facility Name (if not institution, give street and number) cation of Death 4c. County of Death **Examiner** Homore errace If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 8 L **Funeral** 1 **№** M 2 🗆 F Days Hours Min. Month, Par **Director** 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at angle event. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director Baltimore Yes 2 🗆 No 10e. Street and Mombe 10g. Citizen of What Country? Funeral USA errace . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes, Give Baltimore, Maryland 21215-0036 1 🗆 Yes 25 No Specify 3 ₩Vidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DOWOT useretired) 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) /Seconday (0-12) Be ame (First, Mig ဂ္ဂ len 19a Informant's Mame/Relationship (Type, Print) lan 20a. Method of Disposition

1 De Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or ether place oarrison 10-12-10 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Entertile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresi Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of, or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown detached Unknown יי שופיז שוופיז שוופיז שוופיז Atter this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has be autopsy performed? Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#19a, perFH C908, 10/7/2010 WS State of Maryland Department of Health and Mental Hygiene AMEND ITEM#29c, perDVR, C920, 10/6/2011, WS AMEND ITEM#29c, perDVR, C920, 10/6/2011, WS 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley Dean
4a. Facility Name (if not institution, give street and number) Month Year 2:14 am October 2010 Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Harbor Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗹 F Days Months Min (Month, Day, Year) Hours Yrs Director 216-60-7050 Jun 6, 1953 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🕇 Yes 2 🗆 No Glen Burnie Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Summerwind Way 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Completed Black 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) A. A. County Schools Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bernice Johnson Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Dwayne Cox 156 Bethel Springs Drive Northeast, Md. 21901 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 10/11/10 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum Signature uneral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. For the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, an eart failure. List only one cause one of line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) eiomy ocarcoma Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Directo for as a nonsecritimae of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? io the runeral Director, After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Records, 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ☐ Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 M No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 M Natural 5 Pending injury after death Accident Investigation М 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical E Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hanover Street Baltimore. MD 2125 Don 32. Registar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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F	- B.		Decedent's Name (First, Middle, Last)					of Death 3. Time of Death				
7	Physici /Medic		James Harold Do			Se		19 201	0 9:30PM			
	Examir	ner	4a. Facility Name (If not institution, give st		4b. City, Town, o	r Location of	Death		c. County of Dea	th /		
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Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship (Type Sharon Doney/spou	,		ng Address (Street Ourtime					Zip Code)	
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alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Ronald S	de Nivecto	r 2	2. Name and Addre	ss of Facility	Soard 65	5 W. F	Raltimore	Street	
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THE WAY	Physician /Medical Examiner		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee									
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Ξ.	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho	spital: 1 ☐ Inpatient 2 [☐ ER/Outpatier	nt 3□ DOA Oth	or A	of Death (Check		6 □Other (Spe	oif.d	
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Division	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office			ition (Street or Town, Sta	(Street and Number or Rural Route Number, own, State)		
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 medical Examine one)	 r: On the basis of examination and manner stated. 	nation and/or in	vestigation, in my	ppinion, deat	h occurred at the	time, date a	and place, and du	e to the cause(s)	
	To the comp	ž	29b. Signature and title of oertifier			29c. Licens	e number	· ·	29d. D	Date signed (Mpni	th, Day, Year)	
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	1		30. Name and address of person who com				1 .	MD 01/0	. 1			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 2010 3:05 Рм Dolores Dunholter Dunholter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Hillwood Group Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 11y 22,1911 1 □ M 2 🕱 F Months Days Hours Min Pennsylvania 276-54-4221 99 Director July Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🏝 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 7401 Bradley Boulevard <u>United States</u> 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John DePree Genevieve Crosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Schwartz / Daughter 7913 Kentbury Drive Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 Burial 2 😾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) October 5, 2010 Bethesda, Maryland 21. Signature of Funeral Service Liver Robert A. Pumphrey. Funeral Home Bethesda-Chevy Chase, 7557 Wisconsin Avenue Bethesda, Maryland 20814 MO 1607 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Aspiration Pneumonia Medical Due to (or as a consequence of) **Examiner** Dysphagia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Dementia, Alzheimer's type attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Day Other (specify) Pregnant at time of death 2 X No 1 Yes 2 2 Unknown s been signed by the same should be detached a | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hypertension, history of 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Transient Ischemic Attacks autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify Group Home 1 🗌 Yes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours a er decti Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, þ determined City or Town, State) Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year, OCT 0 7 2010

Susan J. Miller, M.D. 8281 Wisconsin Avenue

D35579

2010

10/05

#305 Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day Year Month CAROLYN 702 PM DUNNYER 09 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CENTER Baltimore MEDICAL MD 5. Social Security Numb 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-46-2996 1 🗆 M 2🏋 F Days Hours Min Country) MD 65 Director 5/ Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Nottingham MD 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 9522 Perry Hall Blvd USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Statistical/Accountant Accounting 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname), Irene Belle Wolverton 2 James Franklin Wheat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce H. Dunmyer Husband 9522 Perry Hall Blvd Nottingham MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial Cremation 3 Removal from State cemetery, crematory or other place)
Atlantic Crem 10/06/10 Glen Bernie MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Simplicity Crem & Fun Ser ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ epticenia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or se a donanglinhou of) cause. Enter Underlying Cause (Disease or linjury the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a ld be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

e Funeral Director. After this certificate has the Funeral director, page 2 to the fineral director, page 2 to the fineral director. autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 ¥ Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 [only one 29b. Signature and title of certifier Oc. License number 085448 29d. Date signed (Month, Day, Year) 09,30,2010 AU4176435 T1900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar m

31. Date filed (Month, Day, Year)

nrt 0 7 2010

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32. Registra's Sign

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BAUTMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a Per FH G908 10/07/10 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 **Physician** 201 12:20 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MANSITIONS HEALTHCARE SYKESVILLE CARROLL If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F Months 7834 Days Hours 810 21 Director JULY 17 1932 VIRGINIA WEST Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits CARROLL 1 ☐ Yes 2 X No Director SYKESVILLE MO UNITO 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r USA 2014 21784 SERRA DRIVE Funeral 27 Is marked other than "natural", or items traumatic event, the Medical Examiner mi 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed by Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) MANAGER PROVINENT BANK 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HALLIE COCHRAN ည WILLIAM 7. JENNINGS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s1 and 2 s of Health a 2014 RUDY SERRA DR. UNITIO SYFESVILLE MO 21784 1HUSBAND LCONARO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/7/2010 4 Donation Strother (Specify) Entombment LAKEVIEW MEM. PK SYKESVILLE, MO 22. Name and Address of Facility J N ZUMBRUN FIT & MON CO. 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SYFESVILLE RO ELDERSBURG-MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final Athenosclerotic Cardiovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of certificate be executed burial-transit and Due to (or as a consequence of): nding physician ause as the burial Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 | Yes 2 | No 3 | Probably 4€ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29th Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Typo Pript)

TARLY MALMUUD 19, Rude Rual Westminstr 32. Registrar's Si State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2, Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 27 2010 Physician/ 7:30A.M. Paul Joseph Demasky Sr. Atember Medical 4c. County of Death la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Ctr Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 🕱 M 2 🗆 F Hours (Month Day, Year) 001-24-5327 75 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director Examiner must be notified 28a-f 1 ☐ Yes 2XX No MD Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? ò 10e, Street and Number items 23a Funeral 354 Council Oak Drive 21144 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

X Yes 2 No Black, White, etc ģ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 53-73 Specify: White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic. College (1-4 or 5+) Elementary/Seconday (0-12) Operations Manager Convention Services Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph W. Demasky Veronica Denoncour 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 354 Council Oak Drive Severn, Maryland 21144 Donna Demasky Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10-1-2010 Crownsville, Maryland Crownsville Vet Cem Signature of Fundral Service Lice 22. NDOALLESSAFTUneral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 M01176 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) signed by the a d be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 🗌 Yes 2 🗌 No of Vital Records, peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy perform 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. injury 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28c. Injury at 28d, Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 \square Pending Natural Accident Division Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion doubt account and the cause(s) and manner as stated. within 24 hours a Medical 29a. Certifler 2 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar OHMH 17 Rev 7/2009 29b. Signature and title

30. Name and addr anola

31. Date filed (Month,

Year)

VEMASKY

person who completed cause of death (Item 23a) (Type, Print)

32. Regi

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Durant 1759 2010 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CO NORTHWEST HOSPITAL CENTER RANDALLSTOWN 8. Date of Birth (Month, Day, Year) FEB 12 1942 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Sex 1 X M 2 □ F Hours MARYLAND **Director** 68 219-38-3024 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MARYLAND BALTIMORE CATONSVILLE 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 3 SLATE MILLS CT. 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 70 / 72 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 Widowed 4 Divorced Year or Dates. 70/72 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BUS OPERATOR TRANSPORTATION 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ EVELYN JOHNSON JOHN H DURANT SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen C. Durant/Wife Slate Mills Ct., Catonsville, Md., 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 10-13-10 OWINGS MILLS, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a co Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a g ☐ Unknown signed by the a 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No this certificate 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

OCT O

7 2010

32. Registrar's Signature

211 33

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 9:50P Herbert L. Ellingson, October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Toowson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 ★ M 2 🗆 F Months 1 2 - 9 - 1 9 3 9 Director 219-26-2494 70 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6920 Conley Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Processing Esskay Meat Packer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Herbert Ellingson Cornelia Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Herbert L. Ellingson, California Ave., Baltimore. Jr. 3109 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 10-7-10 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Li 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) estive pro Medical Due to (or a a consequence of): Examiner orcoany cusoticily list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician the detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate has page 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: 2 **N**0 1 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending Investigation Accident 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

UCI U 7 ZUNU

32 Registrar's Signatur

Strylos Buttomer MODISO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 5 2010 ear Pamela Ann Elliott :36 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson **Baltimore** 5. Social Security Number If Under 1 Year **Funeral** 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 🔭 Months Hours Min. 4/3/1962 ear) **Director** 216-88-6567 48 Yrs Connecticut Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore or 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2505 Anders Road 21234 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 Never Married 2 X Married 1 Yes Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Insurance Underwriter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Thomas Tyrrell Elizabeth Capuano 19a. Informant's Name/Relationship (Type, Print)
Steven Jeffrey Elliott /Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 Anders Road Baltimore. Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or 10/9/2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dulanev Valley Mem Signature 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. W <u> 1050 York Road Towson, Maryland 21204</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ cancer Meta static disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Hospital or Attending Physician: The law requires that the death 24 hours after death.
Funeral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed in page 2 should be det 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🔀 2 🗌 No 1 🗌 Yes Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA HOSDICE To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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Patel

29b. Signature and title of certifier

State Registrar

32. Registrar's Sig OCT 07 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death October 5, Physician/ 2010 Eva Mary 7:15a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Co. Marlyn Place Assisted Living Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months DEC'23", 1919 90 Maryland 213-10-2312 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Md. Baltimore Essex 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 809 North Woodward Drive 21221 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) 9th College (1-4 or 5+) Mental Hygiene. Production Line Esskay Meats Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Bebnowski Jelen Stephan Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Mullaney, Jr./Nephew Gilley Terrace Rosedale, Md. 21237 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October permit. Page 1 and Department of Informatical Information of Informatical Information of Information of Information of Informatical Information of Informatical Information of Informatical cemetery, crematory or other place)
Holly Hill MemGar 8, 2010 1X Burial 2 Cremation 3 Removal from State |Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A 201 Dundalk Avenue Baltimore. Md.21222 23a. Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardiovascular Hypertensive Medical resulting in death) Due or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 X No 1 Tyes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Hospital 1 ☐ Yes 2 🖾 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛛 Other (Specify) Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation the Funeral Director: upleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 — Curtifying Nume Franticion: T. The control of the control of the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mulu IN D18598 10-5-2010

State
Registrar

DHMH 17 Rev 7/2009

👂 110 Philadelphia Rd. Suite 206 Baltimore,

21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Sheldon Milner,

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montapher 9. Birthplace (State or Foreign If Under 1 Year 1 Under 2 8. Date of Birth Social Security Number **Funeral** 1-09-1917 1 □ M 2 X F Months Hours Country) 92 091-14-9361 Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State **Funeral Director** 1 X yes 2 □ No Bowie MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 20718 P.O. Box 1253 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates Specify 3 X Widowed 4 ☐ Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) EPA Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ethel Mae Draper Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 1253 Bowie, MD 20718 19a. Informant's Name/Relationship (Type, Print) Leslie Vinson/Son Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10-7-2010 Riverdale Park Crem. Riverdale, MD 4 Donation 5 Other (Specify) 22. Name and Address of FaciliRonald Taylor II FH Sonature > Funeral Service License 10583 Middleport Ln. White PLains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5 months disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of Examiner 7 years Aortic Stenosis Sequentially list conditions, Examine Due to lor as a consequence of If any leading to immed cause. Enter Underlying use as the burial-transi Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Month Day ō 5 Other (specify) Pregnant at time of death signed by the a d be detached for 1 ☐ Yes ∠▲ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s performed? Yes 2 No 1 ☐ Yes 2X No this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital director, Be Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1X Natural 5 Pending work? 1 Yes 2 No n 24 hours after death.

Re Funeral Director: Alpleted filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the 29c. License number 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year,

State Registrar

DHMH 17 Rev 7/2009

acks

32. Registrar's Signature

10810 Darnestown Rd. Suite 202 Gaithersburg, MD 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tuli M.D.

31. Date filed (Month, Day, Year)

OCT 072010

Please Type or Print in Black Indelible Ink. 15-19-10 Vcopies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician September 20, 2010 4:36 AM Richard Fritz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2912 Bayonne Avenue 1st flr Baltimore 8. Date of Birth 1966 (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numberunk 7. Age (In yrs. last birthday) 6. Sex Funeral Months Days Hours 1 🕅 M 2 🗆 F 44 Maryland Feb 19, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notified at ty□Yes 2□No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number s 1 and 2 should be filed within 72 hours after death with 19 Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or or other traumatile event, it is Modical Examination must be 21214 USA 2912 Bayonne Avenue 1st flr Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry unk un 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley A. Fowler Robert S. Fritz Sr မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traunonce. 2912 Bayonne Avenue 1st flr Baltimore, MD 21214 Teresa Fritz/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in sylate 21. Signature of Funeral Service Licensee 22. Name and Address of Facility rector State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE INFARCTION MYOCKRDIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSIVE CARDIO VOSCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 certificate be by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. BRONCHITIS CHRONIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen: OBESITY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No 1 ☐ Yes 2 ☐ No certificate 1 □Yes Division of Vital Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t pletely filled in by the funera After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the l 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 25-10 Smal M. D. DO017148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONATO A: VA26A5

1706 HARFORD 2045 BALT; MOT Maryland 21214 BOLT:MODZE 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28, 2010 **Physician** 9:15 AMM Raymond M. Frampton September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 8353 Kavanagh Road Dunda1k If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) June 24, 1927 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Hours Months Days Min Maryland 1**X** M 2□ F 83 June Director 212-22-8559 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinal must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2√□No Director Dunda1k MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 8353 Kavanagh Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 45 –4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2X No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 45-47 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) completed) Elementary/Secondary (0-12) College (1-4or 5+) administrator engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wade Specer Frampton Anna Christine Mehring မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael W. Frampton/son 8353 Kavanagh Road Dundalk, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature III neral Service Rona Lo State Anatomy Facility and 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . shock Immediate Cause (Final 2 YEARS Physician APDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examine law requires that the death certificate be executed HYPERTENSION and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for 2 □ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably → ☐ Unknown Completed MRCTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ 1 ☐ 1 ☐ 2 2 ☐ 2 2 ☐ 2 2 ☐ 2 2 ☐ 2 2 ☐ 2 2 ☐ 2 2 ☐ 2 2 ☐ 2 2 ☐ 2 24a. Was an has page 2 autopsy performe DEMENTIA certificate 1 ☐Yes 2X No Division of Vital e Hospital or Attending Physician; 24 hours after death.
2 Funeral Director; After this certificaletely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1∐ Yes 2. ∰ANo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 33407. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,207

State Registrar

DEEPAK

31. Date filed (Month, Day,

Month, Day, Year)
QCT 0 7 2010

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. Registrar's Signature

WISE AVENUE DINDAIR

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N N

State Registrar Ba Yin Oung, M.D. 8
31. Date filed (Month, Day, Year) 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8022 Belair Rd.

M.D.

Baltimore, Maryland 21236

October 7, 2010

Baltimore, Marylan

D0017728

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#24a, 27perPHYS, G908, 10/7/2010, WS

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ 2010 Faulcon 9:501 rol Medical 4a. Facility Name if not institution, give street and number 4c. County of Death **Examiner** City. Town, or Location of Death Himore ltospita Samaritan ge (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral M 2 □ F Months Hours Min Director Usual Residence of Decedent 28a-f show 10a. State any injury or other traumatic event, the Medical Examiner must be notified at City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 0 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Funeral 23a errace 21122 15A items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed orces If Yes, specify Cuban, ō þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give and Mental Hygiene. Is marked other than "natural", 3 Widowed 4 Divorced Blac Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within Be Father's Name (First, Middle, Last) 18. Mother's Name ပ 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Faulcon MD21122 ero 017 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State 20c ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State emetery, crematory or other place) Owings Mills MD 8-2010 4 Donation 5 Other (Specify) Signature of Funeral Service Linensee 21 22. Name and Address of Facility Randal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to lor as a consequence of for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No the detached 9 Unknown 9 Unknown P.O. ģ יט וויס ביווידים עוויס artificate has been signed i completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 100 ပ 1 Inpatient 2 DeR/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work?
1
Yes Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40068991 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roules Blud more mo 21259 Loch 32. Registrar's Signature State arka Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\) Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month octubes FRANKZIN 1: 4519M 201 Medical Examiner Town, or Location of Death 4c. County of Death timore curity Number If Under 24 Hrs. Date of Birth 9. Birthplace (S or Foreign **Funeral** 1 🔼 M 2 🗆 F Months Hours Country) 216-30-0768 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Year or Dates other traumatic event, the M-dical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kobe Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Page 1 and 2 thia 20b. Place of Disposition (Name of cemetery, crematory or other Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or 4 Donation 5 Other (Specify) Signature of Funeral Service Ligensee any 5151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for Month 4 Pregnant Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown P.O. | been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has page 2 autopsy After this certificate 25. Was case referred to m a examiner? Division of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 2 100 ပ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Peath Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Notural injury 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 32. Registrar's Sig State 072010

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Albert Frank, III October 2010 1:00 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Baltimore 5240 - 4th Street Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min. 51 04714/1959 Maryland 217 50 8101 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Baltimore Maryland 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5240 - 4th Street 21225 U.S.A. or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 A Married þ Maryland 21215-0036 1 Tes 2 No Specify: "natural", Specify: 3 Divorced 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) General Maintenance Baltimore City 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Albert Frank pe Mae Marie Overby permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Frank / Wife 5240 - 4th Street Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Carcemation 3 Removal from State Bayview Crematory 10/07/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service. P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 hone Inamerines. . P. 11 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate Yes 2 No 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director. After this certifica eted filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 T Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) the Hospital Medical 🕎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nume Practioners To the best of my knowledge, death occurred at the time, date and place, and due to the c within 2 To the 29b. Signature as d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3021, S. HANOVERSI, Smit 207, BALTIMORE SEENIVASAN MD

DHMH 17 Rev 7/2009

State Registrar 81. Date filed (Month, Day, Year)

🏚 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31428 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year Month Riley Howard Guynn 05:00 PM Sept. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Woodbine Brinton Woods Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) PA. **Funeral** 8/471913^{Year)} 1**₹** M 2 □ F Months Days Hours 97 218-14-7142 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Woodbine 1 Tes 2 No MD. Carroll 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 21797 USA 5417 Woodbine Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Jid be filed withing d Mental Hygiene. (Specify only highest grade completed) (Give kind of wark done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Farmer 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ada Augustus Horace Guynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5417 Woodbine Road Woodbine, MD. 21797 Margaret Guynn/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Memorial: 09/28/2010|Marriottsville, MD. 4 Donation 5 Other (Specify) Funeral Service dicensee Burrier-Queen Funeral Home & Crematory, P.A. 1212 West Old Liberty Road Winfield, MD. 21784 Signature ter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cau Immediate Lause (Final Onset and Death May Physician/ diseas condition resulting in death) Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Récords, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Year Month Day Pregnant at time of death 5 Other (specify) 2 No 4 ☐ Pregnant a 9 ☐ Unknown ed by the 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cellulitis of lower extremity 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an or Attending Physician; The law autopsy director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 TNo 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

and title of portifier

Medus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature

31. Date filed (Month

BUSINESS

32. Régistrar's Signatur

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

STORSTOUN AND

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

DUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ Rebecta Garris 7:57A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balto Northwest Hospice Randallstown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. (Month, Day, Year -5-1927 3. 83 MDDirector 212-22-0375 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore 1 X Yes 2 ☐ No MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 U S 1117 Bonaparte Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed *Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Dunbar Day Care Elementary/Seconday (0-12) College (1-4 or 5+) Cook 10th grade permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Cook Richard Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21218 Mytres Garris-Daughter 1117 Bonaparte Avenue 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) King Memorial Pk 10-15-2010 Randallstown, MD 4 Donation 5 Dother (Specify) 21. Signature of Furral Service 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death End-Stage Cardion yepathu Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ 4 Pregnant Month Day Year Pregnant at time of death 5 Other (specify) 2 No sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate I 2 🗆 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) examiner? 1 ☐ Yes 2 No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pendina n 24 hours after death.

e Funeral Director; Afteleted filled in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical

Registrar

(Check

29b. Signature and title of certifier

No Ray Parket MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 203, Baltimore MD. Registrags Signa re

Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00057465

29d. Date signed (Month, Day, Year)

10/6/10

ICHAEL GWYNN 10-07403 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. LINK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar cedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Medical Examiner 0038 hrs September 27, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore lA 5. Social Security Number If Under 1 Year If Under 24Hrs. 9. 8irthplace (State or 8. Date of Birth (MM/DD/YYYY **Funeral** Months Davs Hours Min Director 62 4404 M 2 F Country) 50 Usual Residence of Decedent À 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Yes 2 No 28a-f show , or items 23a or 28a-f shov r must be notified at once. MD hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Kd 21218 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 1 Yes 2 No 3 Widowed Divorce Yes, Give Year Yes or other traumatic event, the Medical Examiner "natural", \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 I tment of Health and Mental Hygiene. If item 27 is marked other than 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Gwynn Matthews æ Dorothy ပ 19a. Informant's Name/R-lationship (Type, Print) 19b. Mailing Address (Street and Number or ral Route Number, City or Town, State, Zip Code) 605 21229 1 Cousin shadyside KD. Ito. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State portant: 4 Donation 5 Other Specify: mills, md 21. Signature f Funeçal Service Lice 22, Name and Address of Facility Home Bulto meral 2/229 ther be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart List only one cause on each line. Approximate Interval **Physician** Between Onset and Medical Hypertensive atherosclerotic cardiovascular disease Death Imme Life Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit The law requires that the death certificate be executed AMENDED 23a Physician/Medical X UNPENDED PII,27,per ME G910 12/13/10 TT Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 V Unknown Cirrhosis of liver; chronic obstructive Completed 24a. Was an 24b. Were autopsy findings available pulmonary disease autopsy prior to completion of cause of this certificate has performed' death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other: DOA 1 🗸 Yes မ funeral After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Pending Fo the Funeral Director: 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 h ca 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 27, 2010

10 kgrud

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Russell Alexander MD.

31. Date filed (Month, Day, Year)

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Bruce Godfrey 20105:05 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Square HOSPIta Franklin 1 more 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral 1** M 2□ F Months Days Hours Min 217-24-7657 MD 80 Director Feb 28. 1930 Usual Residence of Decedent 10h County 10a State 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercities in ust by nother at Funeral Director Baltimore Parkville 1 □Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 8810 Walther Blvd Apt. 201 U.S.A. 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Y&# Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 🕅 No Completed by Specify. Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Analyst NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be and Mental Lewis Godfrey Alberta Bruce ္ရ should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Pages 1 and 2 Suzanne Godfrey (Wife) 8810 Walther Blvd Apt 201 Parkville, MD 21234 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 10/06/10 Atlantic Crematory Glen Burnie, MD permit. 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, 363I Falls Road Balto, MD 2121 21. Signature of Funeral Service Licenter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) monas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy 25. Was case referred to medical 1 □ Yes funeral director, Be 26. Place of Death (Check only one examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 Yes 2 🗆 No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ceglifier 29c. License number 29d. Date signed (Month, Day, Year, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 T 31. Date filed (Month, Day, Year) Franklin. Drive State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Medical 7,010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death NIA auno althrore If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **M** 2 □ F Months Hours Min. (Month, Day, Year, 214-84-2459 Director 47 2-03-1963 Usual Residence of Decedent 10a. State filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f Baltimore MD 1 X Yes 2 No Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1123 Comet Street 21202 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces Black, White, etc. 1 X Never Married 2 Married þ 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced 4 Divorced Specify: Black Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Hinton Clara Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Jackson 2411E. Northern Parkway 21214 Balto, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Baltimore, MD 10-7-2010 Greenmount 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March Funeral Home 1101 E.North Avenue Balto, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) sensi Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≙ 2 No 3 □ Probably 4 □ Unknown Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? ☐ Yes 2/X No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Tes 1 🔁 Inpatient 2 🗌 ER/Outpatient 3 🗋 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Year work Accident Investigation 1 Tyes 2 🗆 No 24 hours after deat Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2 To the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month.

072010

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sichature

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ John Gilbert Hamilton Oct 5, 2010 Year 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death **Brighton Gardens Assisted Living** Columbia Howard 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Nov 3, 1930 1 ▲ M 2 □ F Months Days Hours Min. 168-24-8534 79 PA Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director MD Howard Elkridge 1 🗆 Yes 2 🗙 No 10e, Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral 23a 5925-J Abrianna Way 21075 U.S.A. items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces? Black White etc. 3/19/1952 ò 1 Never Married 2 Married "natural", or Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give 3/18/1960 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) Clergyman Church permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Hamilton Florence Orosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois M. Hamilton Spouse 5925-J Abrianna Way Elkridge, MD 21075 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metery, crematory or other place)
Atlantic Crematory, LLC 1 Burial 2 Cremation 3 Removal from State Oct 05, 2010 Glen Burnie, MD Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causely neach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (o a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any leading to inmedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed page 2 certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify, 1 Tes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 | No 24 hours after death. Funeral Director: A Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 10 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

State Registrar only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 31435 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Hildre Mary 6:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 629 Walnut Avenue North Beach Anne Arundel **Funeral** Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours (Month, Day, Year) 07/09/194 Massachuesetts Director 021-32-8554 68 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Anne Arundel North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 629 Walnut Avenue 20714 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meagnes. Elementary/Seconday (0-12) College (1-4 or 5+) Property Manager Commerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Edward Charles McGrath Louise Gertrude Delany 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Hildre / Son 9002 Virginia Terrace, Lorton, VA 22079 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 10/05/2010 | Hanover, Maryland 21. Signature of Fundal Service Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ MAMZ MOD Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit Exami that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death both not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe Director; After this certificate of in by the funeral director, page 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Magner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined within 24 hours aft

To the Funeral Di

completed filled in ledical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. S natu 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 31 Date filed (Month 32. Regist State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara Hupkins Month Year 5:50 AM october Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Northwest Hospital Center Randallstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Birthplace (State or Foreign Country)
 MD **Funeral** 7. Age (In vrs. last birthday) 1 - M XXF Days Hours 215-46-8171 0674771945 **Director** 65 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County the Marviand 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 🗆 Yes 2 🄀 No 10e. Street and Number ò 10f. Zip Code must be 10g. Citizen of What Country? with Funeral 6723 Laurel Dr 21207 items ; within 72 hours after death 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or ite the Medical Examiner Armed Forces?

1 🔀 Yes 2 🗆 No
If Yes, Give Year or Dates. 1964-68 Black, White, etc. 1 Never Married 2 Married þ altimore, Maryland 21215-0036 Specify: Black 1 Yes XXNo Specify. 3 X Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 2yrs Homemaker Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname)

Joyce Dowel 17. Father's Name (First, Middle, Last) ပ Milton Redmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 6723 Laurel Dr Baltimore MD 21207 Reginald V. Hopkins II Son other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem Atlantic Crem injury or Department of Important: If any injury or once, Oct 4 10 Glen Bernie MD 4 Donation 5 Other (Specify) Simplicity Crem & Fun Se 7090 Ridge RD Hanover MD or Funeral Service License 22. Name and Address of Facility ThomasAllenPA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Enysician/ Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending phone IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes ∠ ☐ g ☐ Unknown g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2: autopsy performed? 2 No death? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Aatural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certife 29c. License number D0057465 715 Kyapamem 17 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapakse, M.D. 2835 3 m. Th. A. v. 5203, Baltimare, MD. - 21209 N.S. Rajapakse, M.D. 32. Registrate Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			1. Decedent's Name (First, Middle, Las	it)		·				2. Date of Dear	th Day	Year	3. Time of Death
П	Physici /Medic		Sandra H. Just	is						Septemb			2:00 AM M
-	Examin		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, Town, o	Location of	f Death		4c. Coun	ty of Death	
			Oakcrest Villa				Parkv					1timo	
ı	Funeral Director		219-32-8663	ex □M2∏F	7. Age (In yrs. I	77 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Mar 8,	1 ^{yea} r)	9. Birthp Cour Mar	place (State or Foreign ntry) yland
	w w		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						0d. Inside City Limits
	/aryla	5	MD Baltimo	ce		Parkv							1 □ Yes 2 □ No
	the N	rect	10e. Street and Number			1alkv.	10f. Zip Code			1	0g. Citizen of	f What Cour	
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9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evant and the notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Gir Year or D	2) (No ve		Vas Decedent of H fYes, specify Cuba I □Yes 2X1 No	ispanic Orig in, Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: W	
21215-0036	vithin 72 h ene. than "natu	mplete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during m life. DO NOT use retired) executive assi						ost of working			dustry un	
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ılanı	uld be f Vental rrked of tic eve	To Be	Philip Dean Harb	augh						Ida Bri		anoy	
Maryland	nd 2 shoualth and Market 15 is ma		19a. Informant's Name/Relationship (7 K. Douglas Pott		end		g Address <i>(Street</i> Washingt						
Baltimore,	Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State 20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac	e)	D	ate	20c. Location	- City or To	own, State
Balt	permit. Departi Importi any inj		21. Signature of Findral Service Licen	Wady, I	irector		Name and Addre tate Ana altimore	-	Soard 2120		Balti	Lmore	Street
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38760,	icate be executed physician and the burial-transit	dical E	resulting in death) East	d.	(or as a consequ	ience ot):							
9		ledi	IF F51111-5										
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rds, P.	w requires that s been signed b should be deta	by	Part II. Other significant conditions of	ontributing to de	eath but not resu	ulting in the ur	nderlying cause giv	en in Part I.				1/	cause of death?
Vital Records,	nysician: The law re his certificate has be director, page 2 sho	Completed					· · · · · · · · · · · · · · · · · · ·			24a. Was a autops perford		prior to co death? 1 Yes	opsy findings available impletion of cause of
Zi ti	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital: , ,			Out		of Death	(Check only or			
ot	Phys this ral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury	ER/Outpatien 28b. Time of		4 LI Nui		ne 5 Aesid			fy)
on	nding Phy th. After thi funeral	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	th, Day, Year)	Injury	Worl	yaı (? Yes 2∐N		8d. Describe h	ow injury occi	irrea	
Division of	To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, stre	eet, factory, office		2	8f. Location (S City or Town		nber or Run	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 1 ☐ Certifying Phr 2 ☐ Medical Exam	iner: On the b	best of my know asis of examination ner stated.	wledge, death tion and/or in	occurred at the tile vestigation, in my c	ne, date an pinion, deat	d place, a	and due to the ded at the time, o	cause(s) and late and place	manner as: e, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of gen fier	m1-	-1111	1	29c. Licens	number D	0033	624 2	9d. Date sign		Day, Year)
			30. Name and address of person who o	completed caus	e of death (Item	23a) (Type, I	Print)	1/2	1	10			
			1/John	Dow	ns m	D-	7505	051	do	Dritte	302 TO	Julson	, my 21204
	Sta Registr		31. Date filed (Morft), Day, Year) OCT 0 7 201	0	egistrar's Signat	9. pa	ale						•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 6:00 PM M September Samuel Katzoff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice/Northwest Hospital Baltimore Randallstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Aug 3, 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Hours Min. Country) unk Director 230-52-4919 101 1909 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Baltimore Pikesville 10e. Street and Number 10g. Citizen of What Country? by Funeral 23a 751 Mount Wilson Lane 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🕅 No Specify: white Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Johns Hopkins **1**2 professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rachel Snyder Meyer Katzoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 S. Calvert Street #1400 Baltimore, MD 21202 Forrest Bramble/executor Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature Funeral Service Licensee State and Addition Board 655 W. Baltimore Street 21201 Baltimore, MD . Enter the disease, of complications Approximate Interval Between Onset and Death or heart failure. List only one caus-Immediate Cause (Final Therosclustic Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an performed? this certificate completed filled in by the funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at after death. Director: After 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title

State Registrar 31. Date filed (Month, Day, Year)

in B. parki

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:34 P. Mary F. Kegley October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Baltimore 500 Cedar Hill Road Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F 80 Months Days Hours Min 04971371930 Virginia 215 24 1908 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Anne Arundel Baltimore 1 Yes 2X No Maryland 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 21225 U.S.A. 418 Cresswell Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 K No Specify: Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Church Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Walter Owen Araminta Overstreet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Cedar Hill Road Baltimore, Maryland 21225 Linda Sienkiewicz / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 10/06/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Glen Haven Mem. Park Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. Rionel 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnation 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death cate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Tyes ☐ Yes B B 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Daughter's Other: မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Spe Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No. 1 Natural 5 Pending Investigation Accident To the Funeral Director; completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

npleted cause of death (Item 23a) (Type, Print

Registrar's Signa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0020 38 Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Harwood Mandran House 9. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Days **Funeral** 85707 1941 Mary land 1 M 2 K F 69 216 38 2838 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show 10b. County 10a. State Examiner must be notified at by Funeral Director 1 Yes 2 No Essex **Baltimore** Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "-any injury or other trauma**: 249 Sandhill Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Broker Clerk 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Hattie L. Linck William E. Parrish မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Halethorpe, Maryland 21227 1710 Arbutus Avenue Donna J. Miller / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Baltimore, Maryland 1 Burial 2 X Cremation 3 Removal from State 10/02/2010 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death montas Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year in the past 12 months?
1 Yes 2 No Pregnant at time of death cate has been signed by the a page 2 should be detached to 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, | Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical in by the funeral director, Be 4 Nursing Home 5 Residence 6 Other (Specify) MANDRIN Other: Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 I 1 🗌 Yes မ 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death Certificate: 1 PNatural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 29b. Signature and title of certif

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Florence Mae Lambert 1132A M 9 2 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Huspital FRANKLIN Souare Rosedale Baltimere If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Aug 12, 1931 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Months Days Hours Min. 79 Boomer, WV 235-52-0543 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Rem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Macical Evantion is used to notified at West 1 ☐ Yes 2 ☑ No Wyoming Kopperston Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24854 U.S.A. Route 85 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dept. of Elementary/Secondary (0-12) College (1-4or 5+) Social Human Services permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Pomeroy Virginia Bailey Pomeroy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Libby Lilly (daughter) P.O. Box 164 Ghent, West Virginia 25843 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5□Other (SpedWausoleum Palm Memorial Gar: 1, 2010 | Matheny, W.V. 22. Name and Address of Facilitaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee Twhat 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Complications

Due to (o as a consequence of): **Physician** of Left disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopie Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐ Yes 2√☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury un Know M 1 Natural 5 Pending investigation 07-04-2010 1 ☐ Yes 2 ☑ No Fall in bathroom 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 517 ELMWood Rd Home BALTO md 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 27 , 2010 D54715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lopez 9000 FRANKLIN SQUARE DR BULTO md 21237 31. Date filed (Month, Day, Year) State back Registrar

DHMH 17 Rev 1/2001

Amber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04:52 AM William Howard McLean III OCTOBER. 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MEDICAL CENTER TOWSON SAINT VOSEPH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 5, 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 🛛 M 2 🗆 F 1944 220-42-9162 66 Yrs. Maryland **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Baltimore Marvland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 USA 2 Ecoway Court Apt. 1A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Specify: Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William H. McLean Jr. Dorthea Nathatzki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Alsop McLean, Wife Ecoway Court Apt. 1A Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 10/05/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gignature of Funeral Service License Thomas Gregor Pame and Address of Facility Of Maryland, Inc. 19 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director,

Registrar

Medical

State

29a. Certifier

JAMES EBELING 7601 32. Regist a

29b, Signature and title of certifier

determined

tem 23a) (Type, Print)

1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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OSLER DRIVE

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

TOWSON MARYLAND 21204

City or Town, State)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Rea. No. Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Month Year Physician Facility Name (If not institution, give street and number) 010 /Medical 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 214-26-6628 81 Director -14-1929 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore DUNDALK WD 10f. Zip-Code 10e. Street and Number 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with leath and Mental Hygiene.
m 27 is marked other than "natural", or items 23a or the Medical Examiner must be 31999 USA ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify SpecifyWhite à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Schools Dervice 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be NATIUS Dylewsk Helen JAKUDIK မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau W Mikolosk Ken MAR DRIVE EDWARD MD 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 3 ☐ Removal from State 22. Name and Address of Cility 09-08-2010 4 Donation 5 Other (Specify) GLON BURNIE MD 21. Signature of Funeral Service Li 2134 Willow BALLIMD ZIZZZ Ashron F.M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thickrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy or in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 NO ate has been signed by the a page 2 should be detached 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 X+es 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No 2 | July 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 1 🗌 Yes 2 X No 1 Ampatient 2 ER/Outpatient 3 □ DOA 5 Residence 6 Other (Specify) မ After this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) To the Hospital or Attending 1 Natural 2 Accident M 1 Yes 2 🗌 No death. Director: 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 4 - Homicide after City or Town, State) 24 hours a Funeral L 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

tugenie Shieh

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	•		ental Hygie	ene	21111				
			Registrar	ertificate of Death		 	g. Na U U	3 444				
	Physicia	n/	1. Decedent's Name (First, Middle, Last) SHIRLEY MCNALLY			2. Date of Death Month	Day Year	3. Time of Death 5:09 PM				
	Medic		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		OCTOBER	2 2010 4c. County of Dea					
	Examin	er	HARBOR HOSPITAL	BA LTI			N/A					
	Funeral	6.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Und	der 24 Hrs.	8. Date of Birth	g. Bir	thplace (State or Foreign				
	Director		214 20 6201 1 M 2 TF 83 Yrs	Months Days Hours	rs Min.	01/25/1	1927 Ma	ryland				
	d tt	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits				
	aryfar a-f sk fied a	Director	Maryland Anne Arundel Balti					1 Yes 2 No				
	he Mi	Dire	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co					
	with t	eral	4209 - 3rd Street	21225	5		U.S.A.					
	leath Items er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Speci	fy Yes or No-	14. Race - Ame					
98	after c	by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🏝 No Speci		can, etc.,	Black, Whit					
8	ours a	Completed	3 X Widowed 4 Divorced Fres, Give Year or Dates.	cedent's Usual Occupation		1.		White				
15	172 h an "na Medi	ldm	(Specify only highest grade completed) (Gi	ve kind of work done during m . DO NOT use retired)	most of working	'	6b. Kind of Business	Industry				
212	withir giene er th		Elementary/Seconday (0-12) College (1-4 or 5+) H	omemaker			Own I	Home				
nd	filed tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)	18. Mc		First, Middle, Ma	-					
уlа	uld be I Meni narke natic	ř	George Ernest		Olia	I. Lint	on					
Mai	2 shouth and 17 is not traum			ailing Address (Street and Num $oxedsymbol{W.} oxedsymbol{10th} oxedsymbol{Aven}$				o Code) yland 21225				
e,	and Healt tem 2			sposition (Name of	Da Da		Oc. Location - City or					
JOH.	age 1 ent of nt: If i			rematory or other place) te Veteran Cen								
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatural Funda Service License	22. Name and Address of Fac	acility Gor	ce Fune	ral Servi	ce. P.A.				
m	permir Depar Impor any ir once.	(t)	+ Hono Claridge	4001 Ritchie								
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such	as cardiac or	respiratory arrest	9	Approximate Interval Between				
	Physician/	8	Immediate Cause (Final disease or condition _ a CON GESTIVE HEART FAIWRE									
	Medical Examiner		resulting in death) Due to (or as a consequence of):		- III			3 YEARS 5 YEARS				
		ē	Sequentially list conditions, if any leading to immediate		3 (C) (C)							
	ed nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury									
	n and	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
09	ate be executed bhysician and the burial-transit	dical	d									
6876	tificat ng ph as th	Mec	IF FEMALE:									
9 ×	ath certifice attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	B Ctopic pregnancy			23d. Date of de					
Box	e dea the a hed fe	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)			Month	Day Year				
P. O.	hat the		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Pa	Part I.	23e. Did toba	cco use contribute to	the cause of death?				
Š,	requires that the de been signed by the should be detached	Completed by	DIABETES MELLITUS TYPE 2,	HYPERTENSE	ON,	1 🗀 Yes	2 🗆 No 3 🗆 F	robably 4 🕅 Unknown				
oro	w requ	olete	END STAGE REMAL DISEASE,	NYELODYSPI	ASTTO	24a. Was an	24b. Were au	topsy findings available				
Sec	The law ate has page 2	L O	SYNDROME, ATRIAL FIBRILLAT			autopsy performe	ed? death?	completion of cause of				
<u>ro</u>	ian; T irtifica stor, p	Be	25. Was case referred to medical		Death (Check o		2 NO 1 1 10 10	2 - 110				
5	hysic his ce Il dire	0	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpar		Nursing Hom	e 5 🗆 Residend	ce 6 Other (Spec	sify)				
פֿר	ding Physician; h. After this certific funeral director,	Certificate:	27. Manner of Death 1	y work?		d. Describe how	injury occurred					
Sioi	death ctor: /	tific	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2		of Location /Street	et and Number or Ru	ral Pauto Number				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		4 Homicide determined building, etc. (Specify)	one or, reactory, ormeo		City or Town, S		rai noute Number,				
	pspita hours uneral d fille	Medical	29a. Certifier 12 Certifying Physician: To the best of my knowledge, dear	th occured at the time, date ar	and place, and	due to the cause	(s) and manner as st	ated.				
	the Hi nin 24 the Fu Tplete	Med	(Check 2 ☐ Medical Examiner: On the basis of examination and/or invonly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledg									
_	10 VIII		29b. Signature and title of certifier **Mother** MD	29c. License numbe			d. Date signed (Mont					
)			RE5 00			CTOBER					
			30. Name and address of person who completed cause of death (Item 23a) (Type HARBOR HOSPITAL, VISHAL V(ASA	OM. ACAVE	3001	50 UTH	MD 21	VER STREET,				
P	Stat	e	31. Date filed (Month, Day, Year) OCT 0 7 2010 32. Registrar's Significance of the control of th	e del	ワハし	T. 101/7	77119 21					
	Registra	ır	UCI 072010 Cengra p. 190									

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Ling Li, MD

31. Date filed (Month, Day, Year)

O.C.M.E.

October 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6. 2010 Year Richard Charles Migl 7:17 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min Jan 27, Year 921 1 □**X**M 2 □ F 460-18-7899 89 Texas Director Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12201 Burncourt Road 21093 U.S.A. Was Decedent Armed Forces?

1 X Yes 2 No
"Vac Give 44-146 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If Item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Installation Supervisor Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Rudolph Migl, Sr. Mary Mikeska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12201 Burncourt Rd., Timonium, MD 21093 Melva B. Migl-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parkwood Cemetery 1 X Burial 2 Cremation 3 Removal from State 10/09/10 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility William G. Dau Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ cerebrovas wlar no nths Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Penneral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Detal deat
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗌 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Certificate: To 1 Tes 2 **V**No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Ø Other (Specify) #OSPIC & 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural $5 \square$ Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

State Registrar Charles

Baltimore.

MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

2

32. Registrar's Signatur

Partel

31. Date filed (Month, Day, Year)

OCT 072010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year ™I'0 / 5 / 20 I'0 5:31 p M Beverly Lee Norwood 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Days (Month, Day, Year) 11/17/1938 1**X**XM 2 □ F Months Hours 215-34-6034 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Carroll New Windsor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3303 Hooper Rd. 21776 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1★★Yes 2 □ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates. 1956–60 Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Westinghouse

Photographic Manager

20b. Place of Disposition (Name of

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, on each line.

HMYDNODIC

Due to (or s a consequence of):

Due to (or as a consequence of,:

cemetery, crematory or other place)

Pine Grove Cemetery

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3303 Hooper Rd., New Windsor, MD 21776

10/9/2010

Sarah Elizabeth Bowman

²² Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD

clerosis

20c. Location - City or Town, State

Interval Between Onset and Death

5monins

Mt. Airy, MD

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical **Examiner** For State Registral

10a. State

MD

17. Father's Name (First, Middle, Last)

20a, Method of Disposition

Signature of Function

Immediate Cause (Final

Sequentially list conditions

disease or condition resulting in death)

Norvell Lester Norwood

Shelby J. Norwood/Wife

1 X Burial 2 Cremation 3 Removal from State

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

Director

Funeral

þ

Completed

Be

2

Physician/

Medical

Examiner

Funeral

Director

09	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a consected) Due to (or as a consected)				_		
. Box 68760			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fef 4 Pregnant at time of 9 Unknown		23d. Date of delivery Month Day Yea				
of Vital Records, P.O.	sidan: The law requires that the certificate has been signed by irector, page 2 should be detac	Completed by Ph	Part II. Other significant conditions co	ontributing to death but not re	sulting in the underlyin	g cause given in Part I.	1 🗆 24a. Was autop	Yes 2 N	lo 3 🗆 Prob	e cause of death? pably 4 Inknown psy findings available inpletion of cause of
	ificat or, po		25. Was case referred to medical	26. Place of Death (Chec	1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)					
/ita	sicila s cert lirect	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ER/Qutpatient 3	Other	ome 5 🗆 Resid	tence 6 🗆 (Other (Speciful	
	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred			
5	a or Aus s after de al Directo		3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				8f. Location (Street and Number or Rural Route Number, City or Town, State)		
	n 24 hours a ne Funeral C pleted filled	Medical	(Check 2 Medical Exami	ician: To the best of my knowner: On the basis of examination e Practioner: To the best of n	on and/or investigation,	in my opinion, death occurred	at the time, date a	nd place, and	due to the cau	use(s) and manner stated
1	within 2 To the I		29b. Signature and title of certifier	f A	2	9c. License number		29d. Date sig	gned (Month, D	
			1 (hoel	100		D52035		04	6	2010
5+			30. Name and address of person who co			Frence	Westmy	75 fa	Mo	21157
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					
	Registi	ar	OCT 0.7 2010	Denus A.	park					
DHM	H 17 Rev 7/2	009	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 6:40 PM Katherine Nelson 2010 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square 6. Sex HOS Rosedale ranklin Baltimore 8. Date of Birth (Month, Day, Year) Feb. 22, 1918 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□ M 2√ F Months Days Hours Min. 214-07-4032 92 Director MD Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD Baltimore Essex Director 1 ☐ Yes 2 ☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Breaker Court 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify þ White Specify: 3 Kidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Seamstress London Fog 9th Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Frank Fiorita Anna Cella or other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra Iris Powell /daughter Breaker Court Balto. MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Bayview Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/6/10 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. U (05e 05,5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be execute Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 BNo Yea Day 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐Homicide

Division of Vital Records, P.O. Box 68760. 24 hours after death e Funeral Director: within 2

50N

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

Deborah

DHMH 17 Rev 1/2001

110

2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

H0055992

9000 Franklin Square Drive Baltimore,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 Jesse В. Osborne, Jr. P^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Hours July Day O'ear) 1958 216-72-4968 52 Yrs. Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** MD N/A Baltimore 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2439 Ashton Street 21223 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 X Never Married 2 Married 2 X No 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 🗌 Widowed 4 🗌 Divorced White Year or Dates is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Never Worked N/A Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Jesse</u> В. Osborne, Sr. Mary Veronica 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other to once. <u>Jesse B. Osborne</u>, Sr., father 2439 Ashton Street BAltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/06/10 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. MacNabb 299 Frederick Road BAltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 18 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? Yes 2 nours after death.

neral Director: After this certifical filled in by the funeral director. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural work? 1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 5 Pending Μ 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature ap

State Registrar on who completed equse of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 3, 2010 a Richard Roberts 2:30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ፟ M 2 □ F Months Days Hours Min October 14,1916 Director 044-18-0030 New York 93 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bethesda Maryland Montgomery 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral the Medical Examiner must 9707 DePaul Drive 20817 United States , or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 X Yes 2 ☐ No Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Year or Dates. WWII Completed Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter G. Otto Louise Eppens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Linda Haan/ Daughter 1302 30th Street N.W. Washington, D.C. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, 4 ☐ Donation 5 ☐ Other (Specify) October 6,2010 Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home Bethesda—ChevyChase, Inc.
7557 Wisconsin Avenue Bethesda, Maryland 20814 . Signatur of Funeral Service Licensee MO 1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Bilateral Pneumonia hrs. Medical Due to (or as a consequence of): Examiner hrs. Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Aortic Stenosis yrs. ate has been signed by the attending physician and page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 X No 1 🗵 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier Nama>

DHMH 17 Rev 7/2009

State Registrar Aurest

1500

32. Registrar's Signature

glenord Silver Spring

m02091

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NANAZ

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State of I	Maryland / Depa	artment of He		ntal Hygier Reg. 1	711111	31451
Physi		1. Decedent's Name (First, Middle, Last)	Parker				Day Zojo	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give street and numbe The Johns Hopkins Hospital	r)	4b. City, Town, or Lo	ocation of Death	e-toter	4c. County of Death	N/A
Funera Directo		5. Social Security Number 6. Sex 1 M 2 XF 7. Usual Residence of Decedent	Age (In yrs. last birthday) Yrs.		If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea an 31,	r) 9. Birthpla Country 2010 Mary	ace (State or Foreign y) land
Maryland a-f show	ctor	10a. State 10b. County	10c. City, Town or Lo	cation arkville			10	od. Inside City Limits 1 ☐ Yes ※ No
th with the 23a or 28 ust be noti	ral Director	10e. Street and Number 1811 Cobourg Court Apt. A		10f. Zip-Code 2123	34	10g. (Citizen of What Countr	y?
D36 Irs after des Ir, or items xaminer m	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates	s? Xj No	Was Decedent of Hisp If Yes, specify Cuban, IX Yes 2 □ No	anic Origin? (Specify Mexican, Puerto Rica Specify: Puerto		14. Race - America Black, White, et Specify: Whi	c.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 o	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	on ing most of working	16b	. Kind of Business/Indu	ıstry
laryland 2121 2 should be filed within and Mental Hygiene. is marked other than 's aumatic event, the Me	To Be Col	17. Father's Name (First, Middle, Last) Ian S. Parker		N/A	8. Mother's Name (Fi	rst, Middle, Maid a Center	,	
e, Maryland 1 and 2 should be file Health and Mental Hy, em 27 is marked oth	=	19a. Informant's Name/Relationship (Type. Print) Ian S. Parker, Father			d Number or Rural Ro	oute Number, Cit	y or Town, State, Zip C ville, MD	
Baltimore, sermit. Pages 1 an Department of Hee Important: If item any injury or other process.		20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disponsion Cemetery, crem	sition (Name of natory or other place) ematory Inc	Date 10/06/	10 Ba	Location - City or Tow	n, State Maryland
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License Thomas	Gregor Cr	emation So 9 Frederic	of Facility Ciety Of k Road Ba	Maryland ltimore,	d, Inc. Maryland	21228
Physician /Medical	a y	23a. Part 1. Enter the disease, or omplications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	+ Failhr	٧/		spiratory arrest,	1	Approximate nterval Between Onset and Death
Examiner	iner	Sequentially list conditions.	is a consequence or):	stenosi's	•			
58760, Cyrificate be executed a physician and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events c	s a consequence of):	·				
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P.O. BOX nat the death cer by the attendir detached for use	Physician/M	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month D	/ lay Year
Hecords, P.O. Box 68 ne law requires that the death certific has been signed by the attending p age 2 should be detached for use as	by	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given	in Part I.	23e. Did tobacc	o use contribute to the	
The law ate has by page 2 s	Completed					24a. Was an autopsy performed? 1 Yes 2 1	prior to com death?	sy findings available pletion of cause of
r Vital ysician; Th s certificate director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpat	ient 2 ER/Outpatient	Other:	Place of Death (Chapter 4 Nursing Home		6 ☐ Other (Specify)	
or Attending Phys after death. Director: After this in by the funeral d		27. Manner of Death 1 Natural 5 ☐ Pending (Month, Dispension of the control of t	ury 28b. Time of Injury	28c. Injury at Work?		Describe how in		
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	4 ☐ Homicide determined building, ∈	ijury - At home, farm, stre			City or Town, Stat		
the Hosp thin 24 hor the Fune	Medical	29a. Certifier (check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/or inv	estigation, in my opinio	on, death occurred a	t the time, date a	and place, and due to	the cause(s)
	-	Pal		RES-			toter 3	
3	ote	30. Name and address of person who completed cause of PATEEV WADIW 31. Date filed (Month, Day, Year) 32. Registi		Print)	600 Nor		St, Baltimore	
St	ate	31. Date filed (Month, Day, Year) 32. Registi	rar's Signatur and					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3 | 452 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Angela Pollack 3:45PM September Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice/Northwest Hospital Baltimore Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🖵 F Days Hours June 30, 1960 Maryland 218-72-7192 Director 50 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Gwynn Oak 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 Springdale Avenue 21207 USA unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: black er than "natural", the Medical Exa Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Seconday (0-12) College (1-4 or 5+) 0 nursing healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marvis Pollock Mary Fullard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Pollock/mother 4301 Springdale Avenue Gwynn Oak, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Euneral Septice Licenses ROHald S. Marie ී එක්ස්ම්ල් Affa සිහින්ම් Board 655 W. Baltimore Street rector 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Approximate Interval Between Onset and Death shock, ir heart failure. List only one cause on each line Immediate Cause (Final Liver cancel Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam law requires that the death certificate be executed Cause (Disease Or linjur) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year signed by the a d be detached for 1 L Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed pluods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed. Yes 2 V No certificate 1 ☐ Yes 2 ☐ No rector, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specific Pt 1) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After the funeral pleted filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work? 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 1 within 2 To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSKajnpalnem.D 9/28/10

Registrar DHMH 17 Rev 7/2009

State

N.S. Rajapa/LST, M.D.

OCT 0 7 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signature

Smith Avenue,

00057465

Baltimore, MD. 21209.

5-23,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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Matt Phillip Patte		n, Sr. 1- For State Registrar	Sta	ate of Maryla		partment d ertificate d			Mental	Hygiene	Reg. No.	201	0	3 4 5 3
Physicia Medical Examin	in/	1. Decedent's Name (First, Middle,Last) Mat P. Patterson, Sr						2. Date of I Month Octobe		Year		Time of Death 0739 hrs		
1		4a. Facility Name (if			ımber)		4b. City, To	own, or Lo	ocation of Dea			. County of	Death	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Num 1209 Da		Avenue			10f. Zip (Code 218			_	zen of What SA	t Country?	
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Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If iten 27 is m injury or other traumatic.	-1	1 X Burial 2	_		om Stata	crematory or of aklawn	her place)			-9-20			-	i, otate
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/Medical Examiner	-	failure. List only Immediate Cause (Fi		a. Pulmonary	Thromboe	mbolism							Be	etween Onset and Death
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Division of Vital Records, P.O. nal or Attending Physician: The law requires that the ra after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	≥							g				No 3		
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6		Carol Allan, M		stant Medical E	•	111 Penn S	treet, Ba	altimore	, MD 2120	1				
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 2010 Year Oct. Robert D. Patterson 3 9:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) 7. Age (In yrs. last birthday) Date or Day (Month, Day 17 **Funeral** 7^{Year)} 9<u>21</u> 1 ▼ M 2 □ F Months Days Hours Min. 89 Feb. Director 181-12-8296 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural?" any injury or other traumatic events. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Timonium Baltimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21093 19 Hathaway Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coljege (1-4 or 5+) AT & T Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Margaret I. Mahoney John H. Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Hathaway Road, Timonium, MD 21093 Ivy J. Patterson/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/9710 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21093 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signature of Fu Michael Padonia Rd., Timonium, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Widely disease or condition resulting in death) Met Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Day Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Petrent Other: 2 X No ER/Outpatient 3 DOA မ 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 A Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27, Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Pending 1. Natural 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 8125808 V, com 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lewis Villmusia 25h 6701 N. Ch

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT 072010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per dr., g908, 10/07/2010dhb certificate of Death Reg. No. 31455 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ October 1 Frank Charles Rose Sr. 3:11 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) - 1<u>935</u> 1 🕱 M 2 🗆 F Months (Month, Day, Yep. 30, 212-32-5565 Maryland Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 ☐ Yes 2 🛂No Maryland Harford <u>Edgewood</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 119 Red Bud Road 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 9 þ Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗙 No 1 Li Yes ₄ If Yes, Give 1 Yes 2 No Specify and Mental Hygiene. 3 Divorced Specify: Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Instrumentation Technician</u> Steel Manufacturer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit, Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Francis Charles Rose Mary Saranda Nickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Red Bud Rd., Edgewood, MD 21040 Sarah Ann Rose / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christian Cem. 10-5-10 Joppa, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Scherme Immediate Cause (Final disease or condition Physician, W 0 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Hospital or Attending Physician: The law requires that the death in the past 12 months? Month Day Yes 2 No the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, Completed 1 Yes 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes 2 4 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 2 ည 4 Nursing Home 3 Amesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of ath 28b. Time of 28c. Injury at 28d. Describe how injury occurred tural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 3 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature certifie 29d. Date signed (Month, Day, Year) 2010 o completed cause of death (Item 23a) (Type, Print) ss of person who SOODRd. MD21014 31. Date filed (Month, Day, Year) State

Registrar

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Frank

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 31456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RICHBURG Physician/ Month 0121AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bay view Me to huis Hopkins TRACTIMORE CITY TSACTIMONE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth **X**XM 2 □ F Months (Month, Day, Director 219-86-9818 Sent 196 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3216 Kenyon Avenue 21213 USA or items death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 and Mental Hygiene. 1 ☐ Yes 2 XNo Specify. 3 Divorced Completed Specify: Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Materials Mgmt. Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Julius Richburg traumatic Rita Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Tarone Richburg/ Wife 3216 Kenyon Ave. Baltimore, MD 21213 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) Entombment 10/7/10 Woodlawn Cem Woodlawn, 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onse and Delath Physician/ disease or condition resulting in death) Medical Due o (or as a consequence of) Examiner Secure itially list conditions Examine if any, leading to immediate cause. Enter Underlying HID-STAGE RENAL INSEASE Cause (Disease or linjury signed by the attending physician and I be detached for use as the bunal-tran that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exectivithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician at completed filled in by the funeral director, page 2 should be detached for use as the bunal-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No * Month 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No 1 Tyes ☐ Yes 2 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) 1. Yes 2 🔲 No Other: ပ္ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident
Suicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a

State Registrar 31. Date filed (Month, Day, Year)

7 2010

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LG. MEN. HISHC

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 2010 ea Ross Margaret 12:15AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 420 Sudbury Road Linthicum If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days Feb. 12 Hours Mary land 1927 Director 83 214-26-0636 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified at Anne Arundel 1 Yes 2XX No MD Linthicum 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 23a 420 Sudbury Road 21090 USA or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2XX No If Yes, Give Black, White, etc. þ 1 Never Married Married Maryland 21215-0036 1 Yes XX No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic eventone. 18. Mother's Name (First, Middle, Maiden Surname) မ Iris Jones Raymond Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Ardmore Road Linthicum, MD 21090 Mr. Joseph B. Ross, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 0ct cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySingleton Funeral & Cremation Signature of Funeral Service Licensee Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between vello. Varseilas Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death g Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) of certifie 29b. Signature and title mpleted cause of death (Item 23a) (Type,

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Mic

onth, Day, Year)

OCT 07 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09:45 AM OCTOBER Frederick Riedel 2010 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER Tawson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 23, 1928 9. Birthplace (State or Foreign 1**X** M 2 □ F Days Hours 82 Marvland 215-22-3133 June_ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 X No Maryland Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1526 Doxbury Road 21286 U.S.A 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★ Yes 2 □ No WWII
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4 or 5+) Elementary/Seconday (0-12) Captain Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Riedel, Sr. Bessie North 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Riedel 1526 Doxbury Roed Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (9 - 1/1) 20c. Location - City or Town, State Date Dulaney Valley Memorial Gardens Donation 5 D Other (Specify) Oct.8,2010 Timonium Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson. Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death SEPSIS disease or condition resulting in death) Due to (or as a consequence of) NEUMONIA Sequentially list conditions. if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death t pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ months? Month Day Year Unknown ificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 26. Place of Death (Check only one)

Physician/ Medical **Examiner** Examiner

Physician/

Medical

Director

Funeral

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Examiner

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Director

1 and 2 should be filed within 72 hours and such a should be filed within 72 hours and Mental Hygiene.
I health and Mental Hygiene.
I lem 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show items 27 is marked other than "attemption", or items 23a or 28a-f show items 27 is marked other than "natural", or items 23a or 28a-f show items 27 is marked other than "attemption", or items 23a or 28a-f show items 27 is marked other than "attemption", or items 23a or 28a-f show items 27 is marked other than "attemption", or items 23a or 28a-f show items 27 is marked other than "attemption", or items 23a or 28a-f show items 27 is marked other than "attemption" or items 23a or 28a-f show items 27 is marked other than "attemption" or items 23a or 28a-f show items 27 is marked other than "attemption" or items 23a or 28a-f show items 27 is marked other than "attemption" or items 23a or 28a-f show items 27 is marked other than "attemption" or items 23a or 28a-f show items 27 is marked other than "attemption" or items 23a or 28a-f show items 27 is marked other than "attemption" or items 27 is marked other 27 is marked other 27 is marked or items 27 is marked other 27 is marked or items 27 is marked 27 is marked or items 27 is marked 27 is marked 27 is marked 27 i

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Baltimore, Maryland 21215-0036

ng physician and as the burial-transit attending physiciar or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 nse for should be detached signed by the peen has

page 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Completed by Physician/Medical Certificate: To Be Medical

	IF FEMALE:
	23b. Was deceder
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ĺ	Part II. Other sign
	Part II. Other sign

29a. Certifier

25. Was case referred to medical examiner? 1 Yes 2 No
27. Manner of Death

Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b Time of (Month, Day, Year)

4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

TOWSON.

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
9b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day,
Ille Liles.	D0067248	10/4/18

D0067248

7601 OSLER DRIVE

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRETCHEN DICKINSON, M.D. 31. Date filed (Month, Day, Year)

2. Registrar's Signature

State Registrar

2+

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM 10d, per FH, G909, 11/23/2010, WS. State of Maryland, Department of Health and Mental Hygiene Certificate of Death Day 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DUTOBER 2010 Marie Dix Robinson /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MORE AUNES GOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2**X** F Months Days Hours Min. Director 215-22-2226 84 07/24/1926 Maryland Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Mucical Examinat must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1X Yes 2X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 Windsor Garden Lane, #316 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 X Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Healthcare 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Saunders Dix 2 Emma Sturgis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8643 Gateshead Road, Alexandria, VA 22309 Gloria Dean / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 10/05/2010 | Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Litensee 22. Name and Address of Facility Anatomy Gifts Registry VI 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** OBSTRUCTIVE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) if any leading immediates. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760. attending physician The law requires that the death certificate be Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav Year ☐Yes 2 No 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No Division of Vital 1 □ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMMONDS FERRY RD BALTIMORE, MD 21227 HASAN

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ROBINSON

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robinette Raleigh Month Year 1:15 P october 7610 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1008 West Mosher Apt A Baltimore Baltimore 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 1 □ M 2 V Days 217-94-8333 2/3/1968 **Director** 42 Heual Residence of Decedent 28a-f show 10a State 10b. County with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1008 West Mosher Apt A 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Never Married 2 ☐ Married ☐ Yes 2 🔀 No Yes, Give δ 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Worker Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pete Maxine Elizabeth Raleigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floretta Tillman Aunt 1008 West Mosher Apt A Baltimore MD 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 10/06/10 4 Donation 5 Other (Specify) Glen Bernie MD 22. Name and Address of Facility Simplicity Crem & Fun Ser ThomasAllenPA 7090 Ridge Rd Hanover MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Colo-Rectal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or iirijury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ohysician and the burial-transi Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number MSRajapahieM.D 10057465 10/6/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N S Rojapaks M B. 7835 Smilh Av.

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

7 2010

32. Registrar Signatus

5-205

Baltimor, MD. 21209.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O'C+cber Physician/ Stewart Vernice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Prince Regional Laurel Hospital George's Laure 8. Date of Birth (Month, Day, Year) 08–29–1928 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🛛 F Hours Director 577-40-2344 VA. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ?? - - any injury or other traumatic event, the North Control once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Yes 2 No Burtonsville Montgomery MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20866 U.S.A. 14722 Wexhall Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) brivate Social Worker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary Elizabeth Coston William Coston Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
722 Wexhall Terrace, Burtonsville, MD 19a. Informant's Name/Relationship (Type, Print) Zakia Williams-Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State Riverdale Park Crematory 10-7-10 Riverdale, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home 2 Signatur of Funeral Service Licen A 108 W. North Avenue, Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) cochagen Medical Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy Yes 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural injury 5 Pending s after death. 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Laurel Regional Hospital

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

Khirbat

10/3/10

Dusen Road

7300

send

DHMH 17 Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year) State Registrar

Zabiullah Ali, M.D.

32. Registrar's Signature

Assistant Medical Examiner

and address of person who complet a cause of death (Item 23a)

Belled

111 Penn Street, Baltimore, MD 21201

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2 Day 2010 Year 10:50 AM Margaret Louise Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 33 Cedar Drive Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months April Day 2 (ar) 1 M 2 X F 78 1932 Mary Land 218-28-2422 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33 Cedar Drive 21060 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or if edical Examing 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 N Widowed 4 Divorced White Completed Year or Dates. al Hygiene. d other than "natura event, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Kitchen Manager Food Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H 27 is marked of traumatic ever ည Ernestine Kisser Henry Knaus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle L. Laramie / Daughter 33 Cedar Dr., Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 5 Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Aurial 2 Cremation 3 Removal from State Cedar Hill Cemetery Brooklyn Park, Maryland 4 🗆 onation 5 Other (Specify) Rirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Signat e of Funeral Service Licensee MD 21061 Part 1. In ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CORONARY ARTERY DISEA Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Line, Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has all director, page 2 s autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 Hospital: Other: 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred After t 1 X Natural 5 Pending work?
1 Yes 2 No s after death. M Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054739 October 4, 2010 MD

Registrar DHMH 17 Rev 7/2009

State

onna

31. Date filed (Month, Day, Year)

Donna Eversley, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Agnature

7845 Oakwood Rd., Glen Burnie, Maryland 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0855 Edward Spiker Sr Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MHS-Regional Meclical Allegany Center umherland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Social Security Number 6 Sex **Funeral** Sept 17. Country) Maryland 1 🕅 M 2 🗆 F Director 214-28-6261 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location e filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD **Allegany** Cumberland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14236 Louise Drive SW 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Menones. Elementary/Seconday (0-12) College (1-4 or 5+) electrical line man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Freda Elizabeth Warnick ည james Olin Spiker Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14236 Louise Drive SW Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) Julie Spiker/spouse Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses ROTTal d S • Wad Stare and Ariston Board 655 W. Baltimore Street irector 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition BOWEL SCHEMIA Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) Pregnant at time of death a | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA |은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 10-02-2010 20066606 OLAIDE AJAYI, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asayim. b. 12500 Willowbrook Road, Cumberland, MB 21502 Olaide 31. Date filed (M . Registrar's Signat State

Registrar

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 28, 2010 Douglas Smith 3:03 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 311 Park Avenue Salisbury Wicomico 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdav) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Days Hours Min Jan 18, **Director** 217-46-3756 T948 Michigan 62 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 311 Park Avenue 21801 USA items ? "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 N Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) or other traumatic event, the college professor education Be .. Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Russell Smith Luetta Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
311 Park Avenue Salisbury, MD 21801 19a. Informant's Name/Relationship (Type, Print) Philip Johnson/partner 311 Park Avenue Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☑ Other (Specify) in Signature of Euneral Service Licensee Ronal S Was State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause Final Onset and Death Physician, disease or condition resulting in death) Medical Due to (or is a consequence of) Examiner Sequentially list renditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
1 Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ✓ Yes 2 ☐ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0025219 ne and address of person who completed cause of death (Item 23a) (Princess Anne, MD 21853)
Princess Anne Family Practice 31. Date filed (Month, Day, Year) State 32. Registrar's Sigrature 072010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#1perPHYS, G908, 10/7/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Hilda, Rebecca Sieradzki Month 9 Physician/ Year 11:25 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/AHospital Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 301 22 Director 3090 Yrs. Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Anne Arundel 1 🗆 Yes 2 🏝 No Maryland Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 307 Tungston Street 21225 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 to f Health and Mental Hygiene.
If item 27 is marked other than "rother traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles August Dietz, Sr. Ada Leona Shenkel t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Brennan / Daughter 217 Roosevelt Avenue Glen Burnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or or 1 X Burial 2 Cremation 3 Removal from State 10/02/2010 Baltimore, Maryland 4 ☐ Donauon ☐ 21. Signatur of Funeral Service Zic 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Drogestive Hear Medical Due to (or as a consequence of): **Examiner** Stenusis Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a gone-guency of the attending physician and thed for use as the burial-transit Pleural Effusion Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year n signed by the a Id be detached f 1 ☐ Yes 2 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been tibrilla 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? No No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D606 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 7 2010 Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 3 2010 OZZIE В. SMITH 5:18 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE CO 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 25 1934 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2XXF Days Months Hours SOUTH CAROLINA Director Yrs 213-30-6456 76 June Usual Residence of Decedent 28a-f shov 10a. State items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 PENNSYLVANIA AVE. APT 510 21201 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Armed Forces?

1 Yes 2XX No Black, White, etc. ö 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: and Mental Hygiene.
is marked other than "natural", Specify: BLACK Completed 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade HOUSEWIFE N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. CHARLIE GREEN traumatic IDELL EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Dowery/Daughter 1505 Tunlaw Rd., Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 10-12-10 BALTIMORE, MARYLAND 21. Signature of Fundal Switzer 22 Name and Address of Facility WILLIAM C BROWN 1206 W NORTH AVI COMMUNITY FUNERAL HOME P.A. NORTH AVENUE 23a. Part 1. Later the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Panhy po Dituitan'sm Due to (or as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner tury abces Sequentially list conditions, if any maxing to it making cause. Enter Underlying Examiner busite (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown Day Year Pregnant at time of death page 2 should be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Sarcoidosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? After this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Certificate: To Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after death.

Per Funeral Director: After this pleted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 24 only one) 29b. Signature and title of certifier DOU 70 636 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel Bultimore, Leurn 6701 N charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 7 2010 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 () For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 October 11:00A M Simon Robert Medical <u>Herman</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13800 Falls Road Cockeysville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Country) 83 Director 144-70-458 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland **Baltimore** Cockeysville 10e. Street and Number 10g. Citizen of What Country? 13800 Falls Road 21030 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Executive/Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Simon Abrams Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Simon/Wife 13800 Falls Road, Cockeysville, MDImportant: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 10/8/10 Glen Burnie, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clar 23a. Part 1. Exter the disease, or complication that cau shock, or hear failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between MECARDIAL INFARCTON Immediate Cause Final Onset and Death Physician/ disease or condition resulting in death) OUR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated every limit in the cause of the cause Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛃 Natural 5 Pending 1 🗌 Yes 2 \square No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER 0 towson 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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/M	edic	al	Albert J. Spi			September 8, 2010 4:53 PM M								
Exa	mine	er	4a. Facility Name (If not institution 17619 York Ro		nber)		4b. City, Town,		·					
Fune	ral		5. Social Security Number		7. Age (In yrs. I	ast birthday)		erstown r If Under 24	4 Hrs. 8. Date of	f Birth	Vashingto	place (State or Foreign		
Direc		İ	220-16-1707	1 ₹ M 2 🗆 F	84	Yrs.	Months Day	Hours	Min. (Month	, <i>Day, Year)</i> 8, 192	Cou	intry) Vland		
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cd 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Thyrien than "natural", or items 23a or 28a-f show		Funeral Director	11. Marital Status	12. Was Deced	dent Ever in U.S	S. 13. \	Vas Decedent of Yes, specify Cu	Hispanic Origi	n? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Ameri Black, White,			
36 s afte		by F	1 ☐ Never Married 2X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 177Yes	2 □ No		□Yes 217 No		, do no modin, oto	′	Specify: white,			
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hould he market	ŀ	<u> </u>	Nobel Victor Spickler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route							ilda Bowers				
Ma nd 2 s alth ar 27 is			Patsy Ann Spick		2	17619	g Address (Stree York Ro	and Number ad Hage	or Hural Houte Ni. erstown,	MD 2	or Town, State, Zi 21740	p Code)		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 15 marked other than "natural", or Items 23a or 28a-f show any Injury or pulse traumalic event		Ī	20a. Method of Disposition	0 🗆 0	20b. PI	ace of Disposemetery, cren	sition (Name of natory or other pla	ace)	Date	20c. L	ocation - City or T	own, State		
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Physicia	an		Immediate Guse (Final	only one cause on ea	ch line.				- and or respirate	,,		Interval Between Onset and Death		
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COLGS, P.O. BOX 6 w requires that the death certifi been signed by the attending should be detached for use as	1.9	r ilysiciaii/livi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of de		Other (specify)			-	Month	Day Year		
that the detac	4		Part II. Other significant condition	ns contributing to dea	th but not resul	ting in the un	derlying cause gi	iven in Part I.	23e. D	id tobacco u	use contribute to t	he cause of death?		
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aw rec	1 5								24a. W	las an	24b. Were auto	opsy findings available		
On Or Vital Red ding Physician: The lav h. After this certificate has funeral director, page 2.3	potoleano	5	-						— ∣ a	utopsy erformed?	prior to co	empletion of cause of		
VICAL Ician: 7 certifical ector, pa	a		25. Was case referred to medical examiner?					26. Place of	1 □ Ye f Death <i>(Check on</i>		1 □Yes	2 LINO		
Physic rthis or	Ş	2	1 ☐ Yes 2 ☑ No	er color ou		R/Outpatient	3 □ DOA Ot	her: 4 🗆 Nursi	ing Home 5 2	esidence	6 ☐Other (Speci	fy)		
SION (steading Fleath.) tor: After the funeral		<u> </u>	27. Manner of Death 1 ■ Natural 5 □ Pending		Injury , <i>Day, Year)</i>	28b. Time of Injury		rk?	i	Pescribe how injury occurred				
Vittend death ctor: y the	100	2	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot bo	f Injury - At hon	ne farm stre]Yes 2 □ No		ocation (Street and Number or Rural Route Number,				
al or / s after l Dire	Cartification.	3	4 ☐ Homicide determin	building	, etc. (Specify))	et, factory, office			Town, State		ar Houte Number,		
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Fundantal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Modical		29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminer: On the bas and manne	sis of examinati	rledge, death on and/or inv	occurred at the testigation, in my	time, date and opinion, death	place, and due to occurred at the tir	the cause(s	and manner as d place, and due t	stated. o the cause(s)		
To th within To th	M	1	29b. Signature and title of certifier	,1			29c. Licen				te signed (Month,			
			Vincento	A Jans	mt m	0	D00	50362		Sept	ember 9,	2010		
ID		3	0. Name and address of person w	ho completed cause	of death (Item :	23a) (Type, P	rint)	. Hager	stown. M	D 217	42			
	State	3	B1. Date filed (Month, Day, Year)					,	. John, II					
Regi			OCT 0 7	2010	gistrar's Signatu	B. 19	arker							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 4:37 A M Sheldon Shubert Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Number If Under 1 Year If Under 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 D F Months Days Hours Min Jully 11 Year 1929 New York Director 104-20-6415 81 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Maryland Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? Funeral 21030 606 Knollcrest Place, Apt. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, was becedent Ever in U.S. Armed Forces? 1 □Xes 2 □ No If Yes, Give 1946—1949 Year or Dates1 Black, White, etc. 1 Never Married 2 XMarried ģ Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Baltimore County Elementary/Seconday (0-12) School Psychologist Public Schools and Mental Hygier is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shubert Mav Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030ge 1 and 2 sl it of Health a if item 27 is 606 Knollcrest Place, Apt. F Cockeysville, Maryland Barbara Shubert Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillton Service Corp. 10-6-2010 Towson Maryland 21. Signature of Fance at Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 💢 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only. 20071287 Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Swite 4105, Baltimore, NO 6701 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Stansbury Month 1 () 0 4 20^{Year}0 8:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 201 E. Bel Air Ave. Aberdeen 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) 1 □ M 2**X**□ F Days Hours 0 7 / 1 8 / 1 9 1 1 **Director** 99 216-24-0343 Maryland Usual Residence of Decedent or 28a-f show be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Harford Aberdeen 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 201 E. Bel Air Ave. 21001 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo <u>ک</u> 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: Completed 3X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home t. Page 1 and 2 should be filed witterment of Health and Mental Hygientant: If item 27 is marked other 1 jury or other traumatic event, the 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 Constance Watters/Daughter 4056 Gravel Hill Rd, Havre de Grace, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State 1X Burial 2 Cremation 3 🗀 Removal from State Department or Important: If any injury or Harford Mem. Gdns 10/9/2010 Aberdeen 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fun on Service Linnsee 22. Name, and Address of Facility
Tarring-Cargo Funeral Home, P.
333 S. Parke St. Aberdeen, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Dely dration Immediate Cause (Final Dinset and Death Physician, disease or condition resulting in death) Medical Due to (or as a conseque Examiner 4 weeks alnutrillor Secure dially list our filtrage if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2X No Pregnant at time of death signed by the aid be detached for 1 Yes 2X 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [출 Denjenlia Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate ☐ Yes 2 🗓 No 1 Yes 2 No Director, After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2**X** No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 【XResidence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number Wham D32609 10.5.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harrede Grace, MD21078 evolution St Milhamins Kennudy lioc 1 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

✓ DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LINWOOD TATE OCTOBER 2010 6:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MANOR CARE- TOWSON BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F Months Days Hours Min. Director 216-86-5900 JULY 19, 45 1965 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f sh ther traumatic event, the Medical Experient must be nedified Director 1 X Yes 2 □ No MD BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1234 SHERIDAN AVENUE 21239 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 DISABLED PHYSICALLY CALLENGED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ LINWOOD MALONE ANITA TATE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If item 27 any injury or other troone. ANITA TATE/MOTHER 109 LEE LAWRENCE COURT BALTIMORE, MD 21222 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 10-8-2010 BALTIMORE, MD STANTSLAUS CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 18800015 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caucs. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 000 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certified completely filled in by the

Medical 2 2

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

IthA

WA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

29a, Certifier

(Check only

8813

29b. Signature and title of certifier

Woods

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4BONICA

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G908 10/12/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5^{Day} 2010 Ramona Charlotte Wesley 10:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1609 Jennings Road Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min 1-30-1944 Hours Country) MD 1 M 2 XF 238-70-6466 66 Director Usual Residence of Decedent or 28a-f show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.

outrant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho ovclart: If item 27 is marked outher than "natural", or items 23a or 28a-f sho ovclart: Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1609 Jennings Road 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Clifford Russell Clara Golden 19a. Informant's Name/Relationship (Type, Print) **Dabrasky**Clara Debrowski / dau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 1609 Jennings Rd. Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 D Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 10/11/2010 Catonsville, MD 21. Signa ore of Tup ral S 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ as ea disease or condition Medical resulting in death) a consequence of Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 1 Yes 2 No signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las autopsy certificate ! 1 Yes 2 No ☐ Yes 2 🗶 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director, Hospital 1 Tes 2 No ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖟 Residence 6 ☐ Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide after death

Director: A

I in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Uny Schuler Can L118354

DHMH 17 Rev 7/2009

State Registrar Oak Point Ct

Pasadena, MD 21122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7900

32: Registrar's Signature

Schuler

31. Date fled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2 2010 2010 Frances Whittington 5:00 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care College Parkway Anne Arundel Arno1d Social Security Number 8. Date of Birth (Month, Day, May 8, 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔽 F Maryland 212-26-4626 Director May 82 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 🔽 No MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 632 Oakland Hills Drive #201 21012 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bank clerk financia1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter Scott King Irene Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Whittigton/son 115 Church Street Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place) 4 ▼ Donation 5 ☐ Other (Specify) . Si mature Service Licer LOLL I S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street irector MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Ph_sician/ addisease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 mooths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Pregnant at time of death 5 Other (specify) 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes · 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ြု 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c. License number In who completed cause of death (Item 23a) (Type,

Registrar
DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ October (Month Pattie Beatrice Waller 2010 1:00 p_{\bullet}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Towson Baltimore Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Days Country) 1 □ M 2 👽 F (Month, Pey Year) 69 228-56-2204 VA Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner micet has a or 28a. 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗓 Yes 2 ☐ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5521 Hillen Road 21239 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2√☐ No Specify: Specify: African-American 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Quality Control McCormick's Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Waller Jr. Pattie Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Gaines/Niece 5808 Obisque Drive, Chesterfield, VA 23832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Woodlawn Cemetery 1 Burial 2 Cremation 3 Removal from State 10-9-2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Sign pire of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nonswall cell disease or condition mon th Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list ounditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mycobacc 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has 1 ☐ Yes 2 ☐ No Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner?
1 Yes 2 No Hospital Other: Hosmze မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after To the Funeral Direct 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner. On the basis of examination and so involged on, in the property of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number DOU" 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierel 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Date of Month Day Local Ac. County of Death **Physician** EMILY WILLIAMS 0946A.M /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Days Hours 1□M 2 F Director 10c. City, Town or Location Ral-HIMOre 10d. Inside City Limits 10a State 10b. County or 28e-f show other traumatic event, the Modical Exercises has be notified at 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Ie marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Š 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Homemak 17. Father's Name (First, Middle, Last) Be Brown Benninghaus 20b. Place of Disposition (Name of cometery, crematory or other place) od of Disposition permit. Pages i Department of I-Importent: If ite eny Injury or ot once. **Ø** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASEVED **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner?

◆ ✓ Yes 2 □ No 26. Place of Death (Check only one) Other: ≥ ✓ ER/Outpatient 1 Inpatient Certification: To 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No М investigation hours after death To the ...
You the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a subset of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

KALATHIL



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Deat Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 312 Audrey Avenue Anne Arundel Baltimore Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Hours Min 213 36 1160 Director 71 Maryland 24/1938 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 312 Audrey Avenue 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black White etc. ò 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: 3 XWidowed 4 Divorced Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Front Desk Holiday Inn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Knott Bridget O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Walker, Jr. / Son 312 Audrey Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🛚 Burial 2 🗆 Cremation 3 🗀 Removal from State Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/08/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pert 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ DAA disease or condition resulting in death) 50 Medical Due to (or as a consequence **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has I ral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 2 **X**No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes Certificate: 28d. Describe how injury occurred After 1 Natural 2 Acciden injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

0

7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23aPti,27,28a-f per me,g90911/19/2010dhb

For Amend Item 25 per me,g908,10/08/2010dhb

1- State Registrar

Continuous of Decimal Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 26 1927 Rosalee Wilkes Somember 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Citu N/A Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Feb 14, 1911 1 □ M 2 👿 F **Director** So. Carolina 215-28-9952 99 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Examiner must be notified at Director 28a-f 1 Yes 2 No **Baltimore** N/A Maryland 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 21215 USA 3500 Virginia Avenue RosaleeWilkes Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: If Yes, Give Year or Dates Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Baltimore City Schools** Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) as: Department of Health and Mental Important. If item 27 is marked any injury or other traumatic evonce. 0 **Emmaline Coleman Reed** Eddie Reed latient known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 Virginia Avenue Baltimore, Maryland 21215 Emily Staton 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 🕦 urial 2 🗌 Cremation 3 🔲 Removal from State 10/02/10 Windsor Mill, Md. King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Signature & Euneral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et.and Death Immediate Cause (Final Physician/ Sepsis days disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Pheumonia CERTIFICATION APPROVED BY MEDICAL EXAMINER 21 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin Right Hip and Ankle Fracture attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year signed by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial fibrillation, Type I Diabetes Mellits, Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Anemic, Pulmonary Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy nerform death? Yes 25. Was case referred to medica 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28d. Describe how injury occurred fell during transfer from bed to commode, chair height fall no loss of conscious-27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 2 XAccident 5 Pending work 07/25/2010 **Unknown**^M 1 🗌 Yes 2**X** No Investigation 6 Could not be Suicide n'esse 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number or Bural Route Number Pess City or Town, State) 3500 Virginia Ave. Baltimore, MD 21215 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) **RES** 000 1,2010 atober 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Singi Hospital of Baltimore R. Benavides David MP, PhD 31. Date filed 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SHATE Of THE BARGE TO BE BARTING BY JOHN AND AND WIENTED HYGIENE Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month CONdro 1410 PM ams Medical give street and number) or Location of Death **Examiner** of Death 1ton If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In <u>yrs.</u> last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. XISH INGTON DC Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits State filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Completed by Funeral Director 1 🕒 🖍 es 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a ve Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married ☐ Yes 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Volvorced "natural" Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic avant". 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) tousek 18 Mother's Name (First, Middle, Maiden Surname) Be Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Informant's Name/Relationship (Type, Print) State, Zip Code NID 20613 IP.ISON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Riverdate, MD -9-10 verdale Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service 710 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CIRRHOSIS Physician/ -IVER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes 1 1npatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this leted filled in by the funeral dir 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne f Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Matural injury 5 Pending 2 🗆 No Investigation M Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 🖾 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D 0064986 10/3/2010. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1406 B Crain Hwy. S. Ste. 304 Glen Burnie, MD 21061 Chike G. Onwuka 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 1tem 20b per 1h 8908 10-12-10 vt

State of Maryland / Department / Department of Maryland / Department / Depart 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician/ M James Wood Nathanie1 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral (Month, Day, Year Washington, Months Days Hours Min. 1**X** M 2 □ F 63 Feb. 947 Director 578-60-0456 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director 1

Yes 2 □ No Cockeysville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r United States 21030 Funeral 10404 Cranbrook Hill Pl. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No δ Black hours after Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 College (1-4 or 5+) Private Flementary/Seconday (0-12) Entreprenur 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Rosalee Snook Nathaniel Wood b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7415 Ardwick Armore
Hyattsville, Md. 20748 19a. Informant's Name/Relationship (Type, Print) <u> Alise Assigana / Sister</u> Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition

1 Disposition

2 Cremation 3 Removal from State Unknow cemetery, crematory or other place) 9/10-13-10Maryland Veterans Cheltenham, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Alexander S. Pope. /P
5538 Marlboro Pike/ 21. Signat, re of Funeral Service Lice : e Forestville, Md. 0108 20747 23a. Part 1. Uniter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYDCARLIO disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of). nding physician Physician/Medical certificate be े $\sharp \mathcal{H}$ Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten Month Year in the past 12 months?

1 Yes 2 No ō Pregnant at time of death signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à HYPERTENSION 2 No 3 Probably 4 Unknown 1 Yes Completed peen DIABETIC MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has t ' - - - fillard in hv the funeral director, page 2.5 autopsy 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 X No Hospital: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 16/10

State

Registrar

3

barke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1036 M Virginia Ann Austin 10/0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HICAICE SALISBUR TENINSUUN KegiONAL If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) 4 / 7 / 1 9 2 0 Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Director 220-05-3098 90 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outber than "natural", or items 23a or 28a-f sho amortant: In item 27 is marked outber than "natural", or items 23a or 28a-f sho amortant: In item 27 is marked outber than "natural", or items 25 or 28a-f sho amortant injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Tracy's Landing Anne Arundel 1 🌠 Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 530 North Drive 20779 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Completed by Black White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harriett Richards Charles Stephenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 291 Ripps Dr., Lothian, MD 20711 Charles Austin/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or or once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Mem'l Gdn's 9/27/10 Dunkirk, MD 22. Name and Address of Facility Signature of Funeral Servic License Raymond-Wood F.H., P.A. Dunkirk. 430, Box 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ MY OCANDEAL INFARCTION disease or condition Medical resulting in death) Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnait-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🕱 No Certificate: To 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural
2 Accident
3 Suicid 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) LRW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kene E. Carroll St. 100 md.

State Registrar Desmarais

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 21, 2010 Lewie Gene Anderson Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital 1930 Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 Days Hours March 23, 1945 Director 65 479-48-9671 Usual Residence of Decedent 2010 shov 10b. County 10c. City. Town or Location Director ms 23a or 28a-f sl must be notified Maryland | Montgomery Germantown 17 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral vith 1 SEPTEMBER 19009 Staleybridge Road 20876 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Was Decedent Even Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 K Married 5-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Labor Union Union Represenative ANDERSON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louie Anderson Dorothy Mae Blair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Anderson (Spouse) 19009 Staleybridge Road, Germantown, MD 20876 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 EWIE ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 9/25/2010 Germantown, Maryland 22 Name and Address of Facility De Vol Funeral Nome 10 East Deer Park Drive Gaithersburg, MD 20877 Signature of Funeral Service Licensee 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) MYOCARDIAL INFARCTION ACUTE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate outse. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month signed by the and be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 VENTRICULAR FIBRILLATION Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? 1 ☐ Yes 2 ☐ No Yes 2 HO eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \sum Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21334 SEPTEMBER 22 2016 30. Name and address, person who completed cause of death (Item 23a) (Type, Print) 15225 SHADY GROVE ROAD ROCKVILLE MARYLAND GOLDBERG DANIEL MD 31. Date filed (Mohin, Day, Year) 32. Registrar's Sig

3. Time of Death

7:30p

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Day

20850

Year

1 ☐ Yes 2X No

Country) Lowa

DHMH 17 Rev 7/2009

State

Registrar

23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VIRGINIA GRAY ARNOLD SEPTEMBER' 8:15 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1503 Mayfield Road Edgewater 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 V F 91 06%VI PY9T9 North Carolina **Director** 231-28-4879 Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Maryland Edgewater 1 🗆 Yes 2 🛱 No 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? United States 21037 Funeral 1503 Mayfield Road should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed Specify: 3 Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea gnos. College (1-4 or 5+) Elementary/Seconday (0-12) Service Worker Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Gur Davis L.O. Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll David Agee/Son 1503 Mayfield Road, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 09/22/2010 Edgewater, Maryland 22. Name and Address of Facilit George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part K Enter the disease or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours at To the Funeral D Medical Certify Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier M. July Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated stated. Figure 1 fixing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Cheal only (ne)

State Registrar 250

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

Marcalus

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32. Rea

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin		4a. Facility Name (If not institution Sanctuary at Holy			nsvill	.e		40	c. County of Death Mon tgon	ו				
Funeral Director		5. Social Security Number 218–80–9199 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Bir (Month, Da May 14,	rth ay, Year) 1915	9. Birt Cou Er	hplace (State or Foreign Intry) ngland		
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vith the N 23a or 2 st be no	eral Di	10e. Street and Number 10719 Meadowhill				10f. Zip Code 20901				itizen of What Co	untry?			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertlal Hyglene. Department of Health and Mertlal Hyglene. Journatur: If the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Wildowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.						ecify Yes or No- Rican, etc.)	-	14. Race - American Indian, Black, White, etc. Specify: White			
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ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Charles Mower 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Johnson								Surname)				
nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (Type, Print) Jane Santorelli/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Creekside Drive, New Hope, PA 18938										Code)		
. Page 1 a ment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State _ C		sition (Name of patory or other place ven Cemete:		Sept	Date • 24, 010		location - City or in			
permit Depart Import any inj		21. Signature of Funeral Service Licenseey 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901												
Physician/ Medical		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the k, or heart failure. List only one cause on each line. Immediate Cause (Final									Approximate Interval Between Onset and Death years			
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the Hospi in 24 hou the Funer ipleted fill	Medical	(Check 2 ☐ Medical E	Physician: To the b xaminer: On the bas Nurse Practioner:	is of examinatior	n and/or investi	gation, in my opinio	on, death oc	curred at	the time, date a	and place	e, and due to the c	ause(s) and manner stated		
To to to to to to to to to to to to to to		29b. Signature and title of certifier	4 M			29c. License number D25344					29d. Date signed (Month, Day, Year) Sept. 21, 2010			
*		30. Name and address person Robert J. Cinsber	who completed caus			rint)	urtons	ville	, MD 208					
Stat Registra		31. Date filed (Morth, Day, Year) SFP 22 20	32. R	egistrar's Signat					·		-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle_Last) 2. Date of Death Month Physician/ Vances Spal 6:30AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎦 F Days Hours Min $M_{ay}^{(Month,Day, Year)}$ 1924 Mary I and 215-20-9622 86 Yrs. Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Braddock Heights 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6140 Jefferson Blvd. 21704 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🐼 No Specify. Specify: White Completed 3[™] Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Le filed with the state of the (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Theater other traumatic event, Be per nit. Page 1 and 2 should be filed Der artment of Health and Mental Hy Important: If item 27 is marked oth any liury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Frances Wachter 17. Father's Name (First, Middle, Last)
James C. Grimes ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Grimes/Nephew 77 Main Street, Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Stauffer Crematory 9/16/2010 4 Donation 5 Other (Specify) Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 our their Enter the diseas mplications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Line nly one cause on ach line Immediate Cause (Final Physician/ re ke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (r as a consequence of) and I-trar sit that the death certificate be executed Exar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year ed by the a 9 Unknown g Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò hypes lipidenik Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No 1 Yes Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director examiner? Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of • Hospital or Attending Pl 24 hours after death. • Funeral Director: After the Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 2 🗌 No M 1 Yes Investigation 2 Accident
3 Suicide
4 Homicide the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 3 29b. Signature and on who completed cause of death (Item 23a) (Type, Print) ANDR JK64 MIS strar's Signature

DHMH 17 Rev 7/2009

Registrar

Rod Black

Please Type or Print in Black Indelible Into Inspire All Gogies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Butler, Jr. September 18. 2010 11:24 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. Date o (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 53 vrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 577-80-8555 1 🛣 M 2 🗆 F Days Hours Min **Director** Washington. Iune. Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland of Mental Hygiene.

In Mental Hygiene.

Marked other than "natural", or items 23a or 28a-f show marked other than "matural", or items 12a or 28a-f show marked ovent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director District of Columbia Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1717 C Street, SE 20003 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Narried 1 X Yes 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify. Completed 3 Widowed 4x Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Security Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ permit. Page 1 and 2 should be in Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e Willie O. Butler, Sr. Lillie Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel E. Alfred - Sister 9707 Glen Way Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 30, Sept. Lee's Crematory Clinton, MD Sunature of Funer Se 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road, NE Washington, DC 20019 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Laryngeal Cancer disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 Dunknown 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 X No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 👿 No 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Set Hymner: No the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D0060634 September 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, MD 20855 Bindr Joseph, M.D. 31. Date filed (Month, Day, Year) SEP 2 4 2010 32. Registrer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bing Clarence Arthur Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Prince George's Doctors Community Hospital Lanham . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 X M 2 □ I August 25, Director 1922 South Carolina 165-16-8936 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director TX Yes 2 No Maryland Prince George's Clinton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 United States 8500 Mike Shapiro Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) American (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tobacco Company Employee Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Mae Holloway Arthur Bing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22408 Michelle Garrison - Daughter 10711 Hamiltons Crossing Dr. Fredericksburg, VA 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Lincoln Mem. Cemetery Sep 28, 2010 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, MD ☐ Donation 5 ☐ Other (Specify) 21. So ature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury hat the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year signed by the a d be detached f Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hhown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an pate has t autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 [__ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 110 ၉ 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Anatural 5 Pending 1 Yes 2 No Accident Investigation ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Abiodun 8118 Good Lucicld, Lanham, md. ee

State Registrar 31. Date filed (Month, SEP 2 4

mD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maureen McCarthy Boland September 19. 2010 12:40 A M Medical Facility Name (if not institution, give street and number) 11221 Stephalee Lane Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Hours 07/23/1923 577-30-0538 Director Yrs Washington DC 87 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural". or iteme 22 and 1-t-10a. State 10h County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD Montgomery 1 Ty Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 Funeral 11221 Stephalee Lane United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 ₩ Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last)
James T. McCarthy 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Mae McSherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sean Boland East Lenox Street Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 09/24^D/2010 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gate of Heaven Cemet. Silver Spring, MD 21. Signature of Funera 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ Weeks disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed' 2 🔀 No 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 XNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this n 24 hours after death.

ne Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Accide Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) 09/20/2010D40216 20

Registrar

State

31. Date filed (Month, Day, Year,

SFP

23

Dennis A. Cullen MD 7625 Wisconsin Ave. #101 Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 09/17/2010 Physician/ KLAUS BERNDT 8:35 P М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Min 1 XM 2 □ F 06/29/1942 Berlin, Director 594-02-0925 68 Germany show 10a State within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Germany 14317 Gaines Avenue 20853 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Fant: If item 27 is marked other thai jury or other traumatic event, the N College (1-4 or 5+) Private Yacht Mechanic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ukn Christel Goedecke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janine Bacquie - personal rep 317 Gaines Avenue, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Dis position (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial → □ Cremation 3 □ Removal from St ceme ematory or other place. 4 Dona 5 Other (Specify) 9/24/2010 Park*la*wn Mem. Park Rockville, MD f Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ Rectosigmoid Cancer Metastati disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury that initiated events Physician/Medical Examine Due to (or as a consequence of): Physician; The law requires that the death certificate be executed burial-transit attending physician a for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 XNo Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: <u>ء</u>| 1 Tes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) Hospice To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) XNatural injury 5 Pending work' 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D0060634 09/18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dindu C.

31. Date filed (Month, Day, Year)

Joseph

23 201

NE, Washington, DC 20017

1160 Varnum Street,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month q Physician/ 6 Am Yea O Na Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Nicomico at the Jalisbur If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** . Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F (Month, Day, Year, 1/25/1929 Country)
Maryland 81 213-24-0695 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Wicomico Delmar 1 🗌 Yes 2 🕱 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 30389 Mallard Drive 21875 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 Army
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. or. 1 Never Married 2 X Married Completed by 1 Yes 2 X No Specify. "natural", Specify: white 3 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) advertising manager newspaper Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Helen Calloway Howard B. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Brown/spouse 30389 Mallard Dr., Delmar, MD 21875 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Wicomico Memorial 4 Donation 5 Other (Specify) 9/23/2010 Salisbury, MD Park 21. Signature of Funeral Service Licenses ²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIUR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last has been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No HOSPIC B 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No /2 Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year. BHIMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AM BOX 33 31. Date filed (Month, Day Registrar's Signature State

Registrar

3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death BLACKWOOD Physician/ Month DROTHY Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Anne Arundel Mandrin Hospice House Harwood Social Security Number 8. Date of Birth (Month, Day Y Oct. 27, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Year 1918 1 M 2 F 91 546-38-6707 ountry) Indiana Director Yrs Usual Residence of Decedent or 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis Maryland 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21409 Funeral 871 Holly Drive South U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give 3**XX**Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Iem 27 is marked other than ' Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) Hugh J. Baker 18. Mother's Name (First, Middle, Maiden Surname)
Anna Brown 19a. Informant's Name/Relationship (Type, Print)
Elizabeth Bowerman/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Stonecrest Circle New Braunfels, TX 78132 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place,
Rose Hill Cemetery 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 9/25/2010 Hamilton, Ohio 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Strvice License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final LION C Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year signed by the a g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 I WS nill 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred HUUIV 1. Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the, best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b Signature and title of contifier Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS MOZIYO DEFENSE/ GHWAY FN J. C NA W

DHMH 17 Rev 7/2009

State Registrar 1 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death September 20, 2010 12:30 Р м Physician /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Riverdale Park Crescent Cities Center Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 17 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Social Security Number 6. Sex ^(Year)1914 Days Hours 1 □ M 2 🗓 F 96 Director 234-03-2508 Usual Residence of Decedent New York 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, it a Medical Evantian in upt by redified at 28a-f shov College Park 1 ☐Yes 2 Y No Prince Georges Directo Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with I Hygiene. 20740 4611 Amherst Road United States by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be file of Health and Mental H fitem 27 is marked oth r other traumatic even Be Rose Kalinstein Sigmund Klein ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Heatherdale Drive, Cincinnati, 0H 45231 19a. Informant's Name/Relationship (Type. Print) Janet Light, Daughter permit. Pages 1 a Department of Hex Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 N Removal from State 09/26/10 Pinelawn, NY Beth Moses Cemetery 4 Donation 5 Dother (Specify) 21. Signature of runeral Service Licensee Törchinsky Hebyew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STOC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 21 N 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other 4 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To rsing Home 5 Residence 6 Other (Specify) 27. Manner of Ath funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending n 24 hours after death.

e Funeral Director: Aft Investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteners of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check onl one) To the within 24 29d. Date signed (Month, Day, Year) 29b. Signaturé tle of certi

12

State Registrar 30. Name ape

AFR 0.0 004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

who completed cause of death (Item, 23a) (Type, Print)

September 20, 2010

Riverdale, MD

6510'Kenilworth Ave., Ste. 1400,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 20, 2010 Year 5:30 p Mary Lee Bush Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Group Home Silver Spring Mon topomery 5. Social Security Numbe 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months Days Hours March 31, Y1921 89 Director 226-26-0759 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Montgomery Silver Spring 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10416 Hayes Avenue 20902 USA , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural" 3 → Widowed 4 □ Divorced Specify: Completed event, the Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2 Owner Furniture Restoration permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, til once. Be . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Emily Duncan Bradford Fishback ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Lee Bush/Son 10416 Hayes Avenue, Silver Spring, MD 20902 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Sept. 22, 2010 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 1160150 Part 1 / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pulmonary Embolus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No 5 Other (specify) Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2XX No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 No Accident. Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nd title of 29b. Signature ertifie 29d. Date signed (Month, Day, Year) Sept. 21, 2010

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of Wendy Wong,

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Drive, #210, Silver Spring, MD 20902

back

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	Funeral Director		5. Social Security Number 126-01-1227	6. Sex 1 XX M 2 □ F	e (In yrs. I	ast birthdaj Yrs.	Months	r 1 Year Days	If Under Hours		8. Date of Bi May 29		917 1	Birth	place (State or Forei York	gn
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ryla	uld be d Men marke natic	Ĕ	Henry Chertoff						Cher							
Maryland	2 shouth and 27 is in traur		19a. Informant's Name/Relations Gordon Chertof:										or Town, State Sprins		MD 20902	
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<u>iii</u>	Page ment c		1 🐼 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ∐ Removal from State Specify)	Mer	Rest noria	ematory or c haven I Gard	ens	⁸⁾	20	-	Fre	edericl	ς, Ι	Maryland	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Funeral Crvice L	licensee			Restha	d Addres	Fuffet	al S	ervice	s, S	Skkot (Cody	y P.A.	
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مسيد	Medical Examiner		resulting in death)	Due to (or as a											0 - 3 - 3	
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Vital Records,	aw req as bee 2 shou	plet								24b. Were	Were autopsy findings available prior to completion of cause of					
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medi	(Check 2 L Medical E	xaminer: On the basis of ex Nurse Practioner: To the b	amination	and/or inve	estigation, in r	ny opinior	n, death oc	curred at t	he time, date a	and place	e, and due to t	the cau	se(s) and manner sta	ted.
	vith To t		29b. Signature and title of certifier	Λ	0	_		License		-			ate signed (M			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		partment of l ertificate of			giene 0 1 0	31497		
	Physici /Medic		1. Decedent's Name <i>(First, Middle, I</i> Donald Elbert Co	·				2. Date of Dea Month 09	Day 2010	3. Time of Death 16:01 M		
malage.	Examir		4a. Facility Name (If not institution, g Garrett County N 5. Social Security Number 6.	Memorial Hosp	In yrs. last birthda	Oakland	If Under 24 Hrs.		4c. County of De			
	Director		236-36-1431 Usual Residence of Decedent 10a. State 10b. County	84	Yrs.				1926	WV 10d. Inside City Limits		
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	ath with the 23a or 2		10e. Street and Number RT 1 Box 77			10f. Zip Code			10g. Citizen of What (
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Maryland 21215-0036	should be filed within 72 hours after death with the Marylan and Mental Hygjene. marked other than "natural", or items 23a or 28e-f show marked other than "natural", or items 23a or 28e-f show marke event, the Medical Examinar must be notified at	Completed &	15. Decedent's (Specify only highest g	Education	16a. Dec	cedent's Usual Occu ve kind of work done b. DO NOT use retire	during most of work	king	16b. Kind of Busines			
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	es 1 and 2 should b of Health and Ment Fitem 27 is marked r other traumatic e		19a. Informant's Name/Relationship Ronald C. Copela			iling Address <i>(Street</i> 1 Box 77,			er, City or Town, State 26717	, Zip Code)		
altimore,	Pages 1 and the second of the		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	cemetery, ci	position (Name of rematory or other pla	ce)	Date	20c. Location - City of			
Baltin	permit. Pages Department of Important: If it any injury or conce.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	14		22. Name and Addre	ess of Facility Dar	vid A. E	Elk Garde Burdock Fur MD 21550	en, WV neral Home, P		
8760,	hysician and physician and stree pe executed physician and stree purial-transit street programmers.	af Examiner	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or heart that initiated events resulting in death) Last	mplications that caused the yone cause on each line. COPD a. Due to (or as a county) onsequence of):	enter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death Years			
C. Box 6	death certi e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	B Ectopic pregnand Double (specify) _	су		23d. Date of c	delivery Day Year		
ds, P.	requires that the een signed by th nould be detache	by	Part II. Other significant conditions CHF w/Ischemic		co use contribute to the cause of death?							
	The larate has	Completed		24a. Was a autop perfor	autopsy prior to completion of cause of death?							
VItal	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpati	ent 3 DOA Oth	or:		th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)			
VIVISION OT or Attending Phys	To the Hospital or Attending Physician; within 24 hours after deal; To the Funeral Director; After this certific completely filled in by the funeral director,	Certification: To	27. Manner of Death 1 🖾 Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 5 Pending investigation of Could not determined	ow injury occurred Street and Number or rn, State)								
	Hospita 24 hours Funeral stely filled	Medical Co	29a. Certifier 1 X Certifying F (Check only one) 2 Medical Exa	Physician: To the best of maminer: On the basis of examiner and manner stated	amination and/or	ath occurred at the ti investigation, in my	ime, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)		
.	To the within To the comple	Mec	29b. Signature and title of pertifier			29c. Licens	se number		29d. Date signed (<i>M</i> o			
	73	10	30. Name and address of person who	·			Cuite TT	001-1	4 MD 0155	0		
İ	Sta Registra		Thomas G. Johnso 31. Date filed (Month, Day, Year) SEP 2 8 20	32. Registrar's			surce II,	Uaklan	u, MD 2135			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ralph Edgar Custer September 29 2010 9:40 P Medical Examiner 4a. Facility Name (if not institution, give street and number, 4c. County of Death Allegany 4b. City, Town, or Location of Death Egle Nursing and Rehab Center Lonaconing 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 1**√2√**M 2 □ F 90 Months Days Hours Min. 214-12-3131 Maryland Director Yrs June 1920 Usual Residence of Decedent shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Barton 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17505 Laurel Valley Drive 21521 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Manufacturer Paper Maker Be 17. Father's Name (First, Middle, Last)
Thomas Cust 18. Mother's Name (First, Middle, Maiden Surname) 2 Custer Blanche Blizzard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17505 Laurel Valley Drive, Barton, Maryland 21521 Armeda G. Custer/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of 10/02/2010 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place. View Cemetery Barton, Maryland Mt. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home anse 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death ⊬nysician/ disease or condition resulting in death) evernon Lac 221 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month detached the 9 Unknown signed by d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by milletus Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No nours after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral D

completed filled in Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17212814

DHMH 17 Rev 7/2009

State

Registrar

21532

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jesus Tan, 4 Broadway, Frostburg, MD

32 Registrar's Signature

31. Date filed (Month, Day, Year)

SEP 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 0857 M CASSIDY September **JENNINGS** Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ROGIONAL SALISHIN MedicaL Wiconia PONINSULA If Under 1 Year I If Under 24 Hrs. Social Security Number 6 Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days PENNSYLVANIA Director 76 165-28-0510 Usual Residence of Decedent 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MARYLAND WORCESTER OCEAN PINES 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 57 BURR HILL DRIVE 21811 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Ъ þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) OFFICE WORKER COMMUNICATIONS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **JENNINGS** CASSIDY W. BERNICE J. AKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 JANET O. CASSIDY/WIFE 57 BURR HILL DRIVE, OCEAN PINES, MD 21811 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TAYLORVILLE CEMETERY 9/24/10 BERLIN, MARYLAND 21. Signature of Flur al Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Che FRING vears Medical Due to (or as a consequence of): Examiner REPLACEMENT ANE weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit that the death certificate be executed Cause (Disease or iinjury that initiated events ESMEY STENDSIS resulting in death) Last Due to (or as a consequence of) signed by the attending physician a be detached for use as the burial-Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed Yes 2 After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c, License number D53551 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 100 E CAKROLL ST. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEF Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31500 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 7:55 P Doris Jeanine Cass September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Vear | If Under 24 Hrs. Washington 9. Birthplace (State or Foreign Country) Golden Living Center 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🛛 F June 5, 79 Maryland 1931 214-78-6635 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 No Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 750 Dual Highway USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 ☑ No White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Hamel Royce Sr. Mary Irene Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 832 Potomac Ave., Apt 2N, Hagerstown, MD 21740 pate of Disposition (Name of Date 20c. Location - City or Town, State Joseph L. Cass / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9/30/2010 Cedarlawn Memorial Park Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac St., Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) clear ceil caucinoma 10 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

and

death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or items 23a

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

72 hours after death with the

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be ပ

traumatic event, the Medical Examiner must be notified

burial-trar physician the as thencing ed by the detached signed b page 2 should certificate has been

Examiner Physician/Medical þ Completed Be မ funeral Certification:

Medical

23b. Was decedent pregnant

1 Inpatient

and manner stated.

1 ☐ Yes 2 No 27. Manner of Death

1/1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

Hospital

28b. Time of Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29c. License number D0066116 29d. Date signed (Month, Day, Year) 9/27/10

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STREET, Hagerstown, MDI 368 MILL

State Registrar 31. Date filed (Month, Day, Year) 2010 32. Registrar's Signature

After this

ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After th

within 24

44-3